MARYLAND HEALTH CARE COMMISSION

COMPREHENSIVE QUALITY REPORT 2014:

COMPARING THE PERFORMANCE OF MARYLAND'S COMMERCIAL HEALTH BENEFIT PLANS

MHCC | MARYLAND HEALTH CARE COMMISSION

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COMPREHENSIVE QUALITY REPORT 2014

On Commercial HMOs, PPOs, POSs, EPOs, and Other Types of Health Benefit Plans in Maryland

Maryland Health Care Commission
Comprehensive Quality Report 2014

* For MHCC contact information please see the back cover of this report.

Letter From the Chair and the Executive Director

Dear Fellow Marylanders,

The Maryland Health Care Commission Comprehensive Quality Report 2014 presents quality and performance information on commercial health maintenance organization (HMO) plans, point of service (POS) plans, preferred provider organization (PPO) plans, exclusive provider organization (EPO) plans, and other types of plans operating in Maryland. The report is a valuable resource for individuals, employers and their employees to compare health plans operating both inside and outside the Exchange on measures and indicators that are closely linked to high quality, value-based care. The key quality metrics in this report are related to health disparities reduction, clinical processes and outcomes, as well as member experience and satisfaction with their health plan and providers.

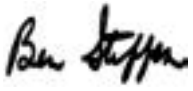
This is the first year of public reporting on a unique quality measurement instrument called the Maryland RELICC Assessment™. RELICC™ stands for Race/Ethnicity, Language, Interpreters and Cultural Competency. The instrument was developed to address the State's priority to reduce health disparities. In addition to measures reported from the standard RELICC™ instrument, we have added information on the distribution of primary care and selected specialty physicians by the county where they practice. We have also significantly expanded our reporting on measures related to the individual consumer's experience and satisfaction with health care.

With the implementation of the Affordable Care Act, MHCC has worked with several organizations to ensure quality information is disseminated as widely as possible, especially to fellow Marylanders who are new to shopping for health insurance coverage. Given our extensive experience in quality and performance measurement and reporting on commercial health benefit plans, MHCC established a collaborative relationship with the Maryland Health Benefit Exchange to produce their quality reports on the performance of qualified health plans that serve Marylanders who purchase health insurance through the Exchange. Visitors to **www.marylandhealthconnection.gov** from October 1, 2013 onward were able to compare the performance of qualified health plans using metrics based on MHCC's annual quality report. MHCC continues working with Maryland Health Connection which provides health insurance subsidies to qualifying individuals, Maryland Department of Budget and Management which administers the State Employee Health Benefit Plan, and other State organizations to ensure that information on health plan quality and performance is readily available and easy to understand.

At MHCC, we are committed to driving continuous health care quality improvement in the State of Maryland through public reporting. The Commissioners and staff hope you find this report to be a valuable resource for locating high quality and affordable health care coverage for you and your family.

Sincerely,

Craig P. Tanio, M.D.
Chair
Maryland Health
Care Commission



Ben Steffen
Executive Director
Maryland Health
Care Commission

Maryland Health Care Commissioners

Craig P. Tanio, MD, MBA, *Chair*, is the Chief Medical Officer at ChenMed, a physician owned group that is expanding access to care for moderate to low income seniors using a model that emphasizes preventive and primary care. Previously, Dr. Tanio was a partner at McKinsey & Company, a global management consulting firm and the Chief Operating Officer for Baltimore Medical System, a group of federally qualified community health centers serving the Baltimore area.

Garret A. Falcone, NHA, *Vice-Chair*, is the Executive Director of Heron Point of Chestertown, a continuing care retirement community on the Eastern Shore. Commissioner Falcone has over 35 years experience in acute and long term care.

Michael S. Barr, MD, MBA, FACP is a board-certified internist and Senior Vice President at NCQA. Previously, Dr. Barr was a Senior Vice President at the American College of Physicians. Prior to joining the ACP staff, he was the Chief Medical Officer for Baltimore Medical System, Inc., and on the faculty of the Division of General Internal Medicine at Vanderbilt University.

John E. Fleig, Jr. is Chief Operating Officer for Mid-Atlantic Health Plan for UnitedHealthcare and is responsible for the overall operations of the health plan and all aspects of the Mid-Atlantic Medical Services, Inc. (MAMSI)/ UnitedHealthcare integration. Before working at UnitedHealthcare, Commissioner Fleig was the Senior Vice President for MAMSI.

Paul Fronstin, PhD is Director of the Employee Benefit Research Institute's (EBRI) Health Research and Education Program, and oversees the Center for Research on Health Benefits Innovation. EBRI is a private, nonprofit, nonpartisan organization committed to original public policy research and education on economic security and employee benefits.

Kenny W. Kan, CPA, FSA, CFA is Senior Vice President and Chief Actuary of CareFirst. He is responsible for the company's healthcare trend and pricing development, claims liability reserving, and actuarial support related to key strategic initiatives. Commissioner Kan previously worked at Legg Mason Capital Management where he was a securities analyst.

Michael S. McHale, MHA, NHA is the President and CEO of Hospice of the Chesapeake, and previously served as that non-profit organization's Chief Operating Officer. Commissioner McHale has over 20 years of experience leading non-profit hospice organizations in Maryland, District of Columbia, Michigan and California.

Barbara Gill McLean, MA retired from the position of Senior Policy Fellow in the Office of Policy and Planning at the University of Maryland School of Medicine. Prior to joining the School, Commissioner McLean served as the Executive Director of Maryland Health Care Commission (MHCC), and as Deputy Director of Performance and Benefits.

Kathryn L. Montgomery, PhD, RN, NEA-BC is the Associate Dean, Strategic Partnerships and Initiatives and Assistant Professor at the University of Maryland School of Nursing. Dr. Montgomery has served in prior faculty and administrative roles at the School after retiring from the United States Public Health Service as Rear Admiral and Assistant Surgeon General within the Department of Health and Human Services.

Ligia Peralta, MD, FAAP, FSAHM is a clinician and scientist with extensive research expertise in the areas of adolescent health, HIV, sexually transmitted infections and health disparities. Dr. Peralta is President and CEO of Casa Ruben Foundation, Clinical Research Institute, and a fellow in global health care innovation at MIT.

Frances B. Phillips, RN, MHA is a consultant focusing on community health improvement and population health innovation. Previously Commissioner Phillips was Deputy Secretary for Public Health Services at Maryland Department of Health and Mental Hygiene and County Health Officer for Anne Arundel County.

Glenn E. Schneider, MPH is the Chief Program Officer for the Horizon Foundation, one of the largest health philanthropies on the East Coast. Prior to joining the Foundation, Commissioner Schneider served as a national consultant, executive director, community organizer, grassroots strategist, and policy director for state/local government and the non-profit sector.

Diane Stollenwerk, MPP is President of StollenWerks, Inc, a consulting group providing strategic, policy and planning advice to corporate, nonprofit and government clients and serves as a technical expert appointed by the Centers for Medicare and Medicaid Services to the panel for the National Impact Assessment of CMS Quality Measures. Previously Commissioner Stollenwerk was a Vice President at the National Quality Forum.

Stephen B. Thomas, PhD is the Director of the Maryland Center for Health Equity and a professor of health services administration at the University of Maryland School of Public Health. Dr. Thomas is an internationally recognized leader in minority health research and community engagement. Dr. Thomas has been a lead investigator for multiple studies on racial differences in health outcomes.

Adam J. Weinstein, MD co-founded the Kidney Health Center of Maryland. He is the medical director for Nephrology and Transplant Services for the Shore Health System (a University of Maryland Hospital affiliate system) as well as some of the dialysis units on the upper Eastern Shore. Dr. Weinstein is the President of the Talbot County Medical Society.

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I. GENERAL INFORMATION

Maryland Health Care Commission

Maryland Health Care Commission (MHCC) is a public regulatory agency whose commissioners are appointed by the Governor with the advice and consent of the Maryland Senate. A core function of the Commission is to evaluate and publish findings on the quality and performance of commercial health benefit plans that operate in Maryland. MHCC publishes this Comprehensive Quality Report as an annual comparative report with the cooperation of the health benefit plans. The annual quality report is a source of objective, comprehensive, independently audited information on health benefit plan quality and performance in Maryland. For more information about MHCC and the reports it produces, visit **http://mhcc.dhmh.maryland.gov**. For MHCC contact information, please see the back page of this report.

Measuring and Reporting on Health Care Quality and Performance

Maryland Health Care Commission (MHCC) is committed to promoting improvements in health care by reporting on the quality and performance of managed care plans operating in the State of Maryland. This year, MHCC continues its 18-year history of advancing health care quality through its leadership in the evaluation and public reporting of commercial health benefit plan quality and performance information. In 1997, Maryland became the first state in the nation to release a comprehensive health benefit plan "report card" that contained audited data on health maintenance organizations (HMOs). In 2008, Maryland was again the first state to provide consumers with audited, comparative analyses of clinical and member satisfaction measures for preferred provider organizations (PPOs).

To help improve the quality of health care in Maryland, MHCC is legislatively charged with establishing and implementing a system of quality and performance measurement and with disseminating findings to consumers, employees, health benefit plans, and other interested parties. Assessing the performance of Maryland's commercial health benefit plans is a critical component of ensuring the availability of quality health care for its residents. Health benefit plan disclosure of quality information using reliable, audited, standardized measures and indicators helps consumers and employers evaluate specific areas and overall performance of health benefit plans. A consistent finding by key organizations such as the National Quality Forum (NQF), the Agency for Healthcare Research and Quality (AHRQ), and the National Committee for Quality Assurance (NCQA) is that health benefit plans that publicly report performance data perform significantly better than those that do not publicly report. The availability of consumer-friendly quality and performance information supports informed health choices, and aids in the selection and purchase of the best quality of care specific to the needs of each consumer, whether the consumer is an individual, a family or an employer. Public reporting of standardized quality and performance measures and indicators promotes competition among health insurance carriers and stimulates health benefit plans' efforts toward continuous quality and performance improvement activities that target consumer needs and expectations.

In theory, the result of developing and reporting quality information is that quality attains a value in the marketplace. As health benefit plans begin to compete on the basis of quality, they will devote greater attention and resources to quality improvement activities. Ultimately, high performing health benefit plans should be rewarded with greater market share as quality begins to influence consumer and employer choice.

The MHCC Comprehensive Quality Report 2014 provides detailed, health benefit plan specific indicators of quality and performance based on measures that include: health care effectiveness through clinical performance, member satisfaction with the quality of health care service delivery, as well as health benefit plan descriptive features and quality initiatives. Readers may draw their own conclusions regarding overall health benefit plan quality and performance as it relates to their specific health care needs.

I. GENERAL INFORMATION

Acknowledgements

Maryland Health Care Commission would like to extend appreciation and acknowledgement to the following state agencies for their contributions to this annual Quality Report and for helping ensure good availability of information on health benefit plan quality and performance:

- Maryland Department of Legislative Services
- Maryland Department of Planning
- Maryland Health Benefit Exchange
- Maryland Department of Budget and Management

Trademarks

II. OVERVIEW

About This Report

The MHCC Comprehensive Quality Report 2014 allows Marylanders to compare health benefit plans on key quality measures from seven categories of health benefit plan quality and performance comparisons. These seven categories include 1. Carrier Disparities Initiatives, 2. Primary Care and Wellness for Children and Adolescents, 3. Child Respiratory Conditions, 4. Women's Health, 5. Primary Care for Adults, 6. Behavioral Health, and 7. Member Experience and Satisfaction with Health Benefit Plan. The measure specific quality ratings show a health benefit plan's ability to deliver high-quality care to its members.

All quality data included in this report are collected from health insurance carriers operating in the State of Maryland who meet pre-defined criteria requiring them to report on the performance of their various health benefit plans operating under several types of health care delivery systems. These delivery systems primarily include health maintenance organization (HMO) plans and preferred provider organization (PPO) plans; however, point-of-service (POS) plans, exclusive provider organization (EPO) plans, and other types of health benefit plan delivery systems may be reporting on their quality and performance metrics in combination with either their parent HMO or PPO, depending on the licensure and structure of the delivery system.

This report highlights areas of health care where health benefit plans had average and above-average performance, and areas that need improvement. In addition, performance rates on each measure and indicator are determined for each health benefit plan. Three comparison points are provided for each measure or indicator when available: the Maryland Average Benchmark (MAB), the National Average Benchmark (NAB) and the National Top Performers (NTP) benchmark. A relative rate comparison for the Maryland Average Benchmark is also presented for each measure and indicator through a three-star rating system, with more stars indicating a better performance for the individual health benefit plan. Specifically, health benefit plans that perform significantly better than the Maryland average achieve three stars. Those that perform at a level equivalent to the Maryland average achieve two stars, and those that perform worse achieve only one star.

As you read this report, you may notice some health benefit plans with a Not Applicable or "NA" rating. When the total eligible population for a clinical measure is less than 30 members, or when the total number of responses for a member experience survey measure is fewer than 100 responses, a performance score of NA is assigned because it is impossible to produce a statistically significant rate with such a small amount of member participation. Additionally, some measures may receive a Not Reportable or "NR" rating when the auditor deems the rate to be biased due to incomplete data. When producing the Maryland Average Benchmark, National Average Benchmark or National Top Performers benchmark, any measure with a NA or NR assigned rate was not included in the benchmark calculations.

Using the detailed performance information, as well as information on Maryland and National benchmarks, plus the consumer-friendly three-star rating system, supports consumers as they make more informed health choices, particularly in the selection of a health benefit plan with the best quality of care specific to their needs. The consumer can select the appropriate category of quality and performance comparisons based on individual criteria and level of importance. For example, a parent with adolescent children may find the category of "Primary Care and Wellness for Children and Adolescents" to be more important than "Primary Care for Adults."

Helpful information on managing chronic conditions and maintaining wellness is also included and can bring multiple benefits, including a longer lifespan, fewer illnesses and an overall improved quality of life. As with all reports, caution needs to be applied in interpreting the performance results, especially when the interpretation of a health benefit plan's quality is based on areas of importance to the reader.

Performance Summary Against Maryland and National Benchmarks

Quality and Performance Measure Summaries

The table below provides a summary of clinical performance measures and indicators, as well as an account of how many of the Maryland health benefit plans had quality and performance scores equivalent to or better than the Maryland average, performance scores at or better than the National average, and performance scores at or better than the top ten percent nationally. Notes specific to each measure, where appropriate, are provided.

Maryland Average Benchmark (MAB): The Maryland Average Benchmark is an average of the rates as reported to NCQA for the health benefit plans in this report. The average is calculated for seven HMOs and authorized HMO combinations such as HMO/POS plan combinations and eight PPOs and authorized PPO combinations such as PPO/EPO plan combinations. If a health benefit plan reported NA, indicating Not Applicable due to an insufficient eligible population (e.g., <30 members) to calculate a rate, or NR, indicating Not Reportable performance results due to bias in the data, then the NA and NR were not included in the calculation of the Maryland Average Benchmark.

National Average Benchmark (NAB): The National Average Benchmark is an average of the rates as reported to NCQA for all of the health benefit plans across the United States and its territories. A mean value of each reported rate is taken from NCQA's *HEDIS® Audit Means, Percentiles and Ratios – Commercial HMO/POS and Commercial PPO Plans*, which is released to the public each year. The NCQA data set gives prior year rates for each measure displayed as the mean rate and the rate at the 10th, 25th, 50th, 75th, and 90th percentiles. NCQA averages the rates of all organizations submitting HEDIS® performance results gathered through the administrative, supplemental or hybrid methods. Therefore, the method for calculating the NAB is the same as that used for calculating the MAB, but on a larger scale. The NABs used here are based on quality and performance reported in 2013.

National Top Performers (NTP) Benchmark: The National Top Performers benchmark represents one of the highest performance levels that can be achieved by health benefit plans. When all of the performance scores reported to NCQA for a particular measure are compared, the NTP marks the bar where eighty-nine percent of the health benefit plans had a lower score and ten percent had a higher score. The NTP is different from the MAB and NAB, which are averages calculated from all reported performance scores. The NTP represents a specific placeholder of all scores reported when they are sorted from lower to higher performance score. It serves as a clear indication and comparison of the health benefit plan's performance in comparison to peers reporting the same product without regard to size of health benefit plan or geographic service area. A health benefit plan is to be applauded if they meet or exceed the NTP benchmark.

Note: Due to NCQA licensing restrictions, the numeric NAB and NTP percentile is not displayed but represented by a line in each of the report's graphs.

Measures and Indicators	Number of Health Benefit Plans Scoring Equivalent To or Better Than the Maryland Average (7-HMO/8-PPO)		Number of Health Benefit Plans Scoring At or Better Than the National Average (7-HMO/8-PPO)		Number of Health Benefit Plans Scoring At or Better Than the Top 10% Nationally (7-HMO/8-PPPO)	
	HMO	PPO	HMO	PPO	HMO	PPO
Health Care Disparities						
Carrier Disparities Initiatives and Provider Network Information, pages 32–45	No Maryland or National Benchmark Comparisons					
Member Information Sources, page 46	5	5	6	5	0	0
Information on Physicians, Physician Office Staff, and Plan Personnel, page 47	3	4	0	1	0	0

continued

Measures and Indicators	Number of Health Benefit Plans Scoring Equivalent To or Better Than the Maryland Average (7-HMO/8-PPO)		Number of Health Benefit Plans Scoring At or Better Than the National Average (7-HMO/8-PPO)		Number of Health Benefit Plans Scoring At or Better Than the Top 10% Nationally (7-HMO/8-PPPO)	
	HMO	PPO	HMO	PPO	HMO	PPO
Health Care Disparities continued						
Using the Data, page 48	5	5	5	5	5	5
Supporting the Needs of Members with Limited English Proficiency, page 49	2	3	1	1	0	0
Assuring that Culturally Competent Health Care is Delivered, page 50	5	5	5	5	1	2
Evaluating and Measuring the Impact of Language Assistance, page 51	7	8	7	8	7	8
Information Available Through the Online Provider Directory, page 52	5	6	No Benchmark*	No Benchmark*	No Benchmark*	No Benchmark*
Interactive Selection Features for Members Selecting a Physician Online, page 53	4	4	4	4	0	1
Health Assessment Programming, page 54	4	4	4	4	4	4
Primary Care and Wellness for Children and Adolescents						
Children and Adolescents Access to Primary Care Providers (12–24 months), page 56	6	4	6	4	0	1
Children and Adolescents Access to Primary Care Providers (25 months–6 years), page 57	6	5	6	7	0	0
Children and Adolescents Access to Primary Care Providers (7–11 years), page 58	5	5	7	7	0	0
Children and Adolescents Access to Primary Care Providers (12–19 years), page 59	5	6	6	6	0	0
Well-Child Visits in the First 15 Months of Life (0 visits), page 60	5	4	5	4	2	0
Well-Child Visits in the First 15 Months of Life (6+ visits), page 61	6	5	6	5	0	2
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life, page 63	6	7	7	7	0	0
Childhood Immunization Status (Combo 10), page 64	6	6	6	6	2	2
Adolescent Well-Care Visits, page 65	5	5	7	8	0	0
Immunizations for Adolescents (Combo 1), page 66	6	7	3	7	0	0
Human Papillomavirus Vaccine for Female Adolescents, page 67	6	6	2	1	0	0

No Benchmark* – No national benchmark available due to significant specification changes for this measure

continued

Measures and Indicators	Number of Health Benefit Plans Scoring Equivalent To or Better Than the Maryland Average (7-HMO/8-PPO)		Number of Health Benefit Plans Scoring At or Better Than the National Average (7-HMO/8-PPO)		Number of Health Benefit Plans Scoring At or Better Than the Top 10% Nationally (7-HMO/8-PPPO)	
	HMO	PPO	HMO	PPO	HMO	PPO
Primary Care and Wellness for Children and Adolescents continued						
Weight Assessment and Body Mass Index (BMI) Assessment for Children and Adolescents, page 68	6	7	3	7	1	0
Counseling for Nutrition for Children and Adolescents, page 69	6	6	6	7	1	0
Counseling for Physical Activity for Children and Adolescents, page 70	6	7	5	7	1	0
Follow-Up Care for Children Prescribed ADHD Medication (Initiation Phase), page 71	4	4	2	2	1	0
Follow-Up Care for Children Prescribed ADHD Medication (Continuation Phase), page 72	3	4	0	1	0	0
Child Respiratory Conditions						
Appropriate Testing for Children with Pharyngitis, page 74	6	6	7	7	1	6
Appropriate Treatment for Children with Upper Respiratory Infection, page 75	6	5	3	5	1	0
Use of Appropriate Medications for Children with Asthma (5–11 years), page 76	3	3	2	2	0	0
Use of Appropriate Medications for Children with Asthma (12–18 years), page 77	3	3	3	4	0	1
Asthma Controller Medication Ratio ≥50% (5–11 years), page 78	4	3	4	5	2	3
Asthma Controller Medication Ratio ≥50% (12–18 years), page 79	3	4	4	4	1	3
Medication Management for Children with Asthma (5–11 years, 50% treatment period compliance), page 80	3	3	4	5	2	1
Medication Management for Children with Asthma (12–18 years, 50% treatment period compliance), page 81	3	3	3	3	1	1
Medication Management for Children with Asthma (5–11 years, 75% treatment period compliance), page 82	3	3	4	4	2	1
Medication Management for Children with Asthma (12–18 years, 75% treatment period compliance), page 83	3	3	2	5	1	1

continued

Measures and Indicators	Number of Health Benefit Plans Scoring Equivalent To or Better Than the Maryland Average (7-HMO/8-PPO)		Number of Health Benefit Plans Scoring At or Better Than the National Average (7-HMO/8-PPO)		Number of Health Benefit Plans Scoring At or Better Than the Top 10% Nationally (7-HMO/8-PPPO)	
	HMO	PPO	HMO	PPO	HMO	PPO
Women's Health						
Prenatal Care, page 85	5	6	1	5	0	0
Postpartum Care, page 86	5	5	1	3	1	0
Breast Cancer Screening, page 87	5	5	5	8	1	3
Cervical Cancer Screening, page 88	6	6	5	7	1	2
Chlamydia Screening in Women (16–24 years), page 89	6	5	6	8	1	1
Primary Care for Adults – *General Health*						
Adult's Access to Preventive/Ambulatory Health Services (20–44 years), page 91	5	6	2	4	0	0
Adult's Access to Preventive/Ambulatory Health Services (45–64 years), page 92	4	6	4	6	0	1
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Adult Body Mass Index (BMI) Assessment, page 94	6	7	2	7	1	0
Colorectal Cancer Screening, page 95	4	6	3	7	1	3
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Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis, page 97	7	7	1	5	1	0
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease, page 98	5	3	3	5	1	1
Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease Exacerbation (Systemic Corticosteroid), page 99	5	3	1	3	0	0
Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease Exacerbation (Bronchodilator), page 100	4	3	3	3	1	0
Use of Appropriate Medications for Adults with Asthma (19–50 years), page 101	5	4	5	4	2	1
Use of Appropriate Medications for Adults with Asthma (51–64 years), page 102	4	3	3	4	0	1
Asthma Controller Medication Ratio ≥50% (19–50 years), page 103	5	3	4	5	1	3
Asthma Controller Medication Ratio ≥50% (51–64 years), page 104	4	3	4	5	0	2

continued

Measures and Indicators	Number of Health Benefit Plans Scoring Equivalent To or Better Than the Maryland Average (7-HMO/8-PPO)		Number of Health Benefit Plans Scoring At or Better Than the National Average (7-HMO/8-PPO)		Number of Health Benefit Plans Scoring At or Better Than the Top 10% Nationally (7-HMO/8-PPPO)	
	HMO	PPO	HMO	PPO	HMO	PPO
Primary Care for Adults – *Respiratory Conditions* continued						
Medication Management for Adults with Asthma (19–50 years, 50% treatment period compliance), page 105	5	4	4	5	1	1
Medication Management for Adults with Asthma (51–64 years, 50% treatment period compliance), page 106	4	4	3	4	1	2
Medication Management for Adults with Asthma (19–50 years, 75% treatment period compliance), page 107	5	4	5	5	1	1
Medication Management for Adults with Asthma (51–64 years, 75% treatment period compliance), page 108	4	3	3	4	1	2
Primary Care for Adults – *Cardiovascular Conditions and Diabetes*						
Cholesterol Management for Patients with Cardiovascular Conditions (LDL-C Screening), page 110	6	5	1	5	1	1
Cholesterol Management for Patients with Cardiovascular Conditions (LDL-C Control <100 mg/dL), page 111	5	5	2	5	1	1
Controlling High Blood Pressure, page 112	5	4	1	3	1	2
Persistence of Beta-Blocker Treatment After a Heart Attack, page 113	3	3	3	5	0	2
Comprehensive Diabetes Care (HbA1c Testing), page 114	6	5	1	3	1	1
Comprehensive Diabetes Care (HbA1c Poor Control >9.0%), page 115	6	6	1	3	0	0
Comprehensive Diabetes Care (HbA1c Good Control <8.0%), page 116	6	6	1	4	0	1
Comprehensive Diabetes Care (HbA1c Tight Control <7.0%), page 117	5	5	0	5	0	1
Comprehensive Diabetes Care (Dilated Eye Exam – Retina), page 118	5	5	2	5	1	1
Comprehensive Diabetes Care (LDL-C Screening), page 119	6	5	1	6	1	1
Comprehensive Diabetes Care (LDL-C Control <100 mg/dL), page 120	6	6	1	6	1	0
Comprehensive Diabetes Care (Medical Attention for Nephropathy), page 121	6	5	3	6	1	1
Comprehensive Diabetes Care (Good BP Control <140/90 mm Hg), page 122	5	5	1	3	1	1
Comprehensive Diabetes Care (Excellent BP Control <140/80 mm Hg), page 123	6	4	1	4	1	1

continued

Measures and Indicators	Number of Health Benefit Plans Scoring Equivalent To or Better Than the Maryland Average (7-HMO/8-PPO)		Number of Health Benefit Plans Scoring At or Better Than the National Average (7-HMO/8-PPO)		Number of Health Benefit Plans Scoring At or Better Than the Top 10% Nationally (7-HMO/8-PPPO)	
	HMO	PPO	HMO	PPO	HMO	PPO
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Annual Monitoring for Patients on ACE Inhibitors or ARBs, page 127	5	6	3	6	1	1
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Annual Monitoring for Patients on Diuretics, page 129	4	5	3	6	1	1
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Follow-Up After Hospitalization for Mental Illness (30 days), page 135	5	5	1	4	0	0
Initiation of Alcohol and Other Drug Dependence Treatment (13–17 years), page 136	2	3	0	2	0	0
Initiation of Alcohol and Other Drug Dependence Treatment (18+ years), page 137	6	4	1	3	1	0
Engagement of Alcohol and Other Drug Dependence Treatment (13–17 years), page 138	3	4	2	2	1	0
Engagement of Alcohol and Other Drug Dependence Treatment (18+ years), page 139	5	6	4	6	0	1

continued

Measures and Indicators	Number of Health Benefit Plans Scoring Equivalent To or Better Than the Maryland Average (7-HMO/8-PPO)		Number of Health Benefit Plans Scoring At or Better Than the National Average (7-HMO/8-PPO)		Number of Health Benefit Plans Scoring At or Better Than the Top 10% Nationally (7-HMO/8-PPPO)	
	HMO	PPO	HMO	PPO	HMO	PPO
Member Experience and Satisfaction With Health Benefit Plan						
Aspirin Discussion, page 141	5	5	No Benchmark*	No Benchmark*	No Benchmark*	No Benchmark*
Flu Vaccinations for Adults Age (18–64 years), page 142	5	5	No Benchmark*	No Benchmark*	No Benchmark*	No Benchmark*
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Getting Needed Care, page 144	5	5	3	2	0	1
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How Well Doctors Communicate, page 146	6	6	2	2	0	0
Customer Service, page 147	3	2	2	1	1	0
Claims Processing, page 148	4	4	2	4	1	0
Shared Decision Making, page 149	4	4	No Benchmark*	No Benchmark*	No Benchmark*	No Benchmark*
Plan Information on Costs, page 150	5	3	2	2	0	0
Health Promotion and Education, page 151	5	6	No Benchmark*	No Benchmark*	No Benchmark*	No Benchmark*
Coordination of Care, page 152	5	5	2	5	1	0
Good Overall Rating of All Health Care, page 153	5	6	3	5	1	1
Good Overall Rating of Personal Doctor, page 154	5	4	5	3	0	0
Good Overall Rating of Specialist Seen Most Often, page 155	5	4	2	3	0	1
Good Overall Rating of Health Benefit Plan, page 156	5	6	4	6	1	5

No Benchmark* – No national benchmark available due to significant specification changes for this measure

II. OVERVIEW

Understanding the Dashboards

The dashboards included in this section contain displays that resemble gas gauges and provide a quick summary of health benefit plan performance across selected measures as compared to National Average Benchmarks. Detailed descriptions to fully explain the measure or indicator and the rationale for why it is important are provided in Section IV, Health Benefit Plan Quality and Performance Comparisons. Page numbers are referenced at the bottom of each display. When interpreting the displays, the reader should pay attention to where the "needle" is on the gauge. There are a total of seven HMOs and authorized HMO combination health benefit plans, as well as eight PPOs and authorized PPO combination health benefit plans.

When looking at the HMO results in a measure, if the needle is on seven, it means that all seven of the seven HMOs and authorized HMO combination health benefit plans performed better than the National Average Benchmark for that measure. For example, the first set of displays focuses on measures related to Primary Care and Wellness for Children and Adolescents and shows excellent performance. The first gas gauge display presents information on the number of children who, during their first 15 months of life, had six or more office visits with their primary care provider. Six of the seven HMOs and authorized HMO combination health benefit plans and five of the eight PPOs and authorized PPO combination health benefit plans performed better than the National Average Benchmark. It should be noted that later dashboards contain similar gas gauge displays which highlight areas for improvement.

II. OVERVIEW

Excellent Performance Areas

Maryland's health benefit plans are maintaining a track record of good performance across many of the measures and indicators being evaluated. However, out of the seven categories of measures and indicators previously listed [1) Carrier Disparities Initiatives, 2) Primary Care and Wellness for Children and Adolescents, 3) Child Respiratory Conditions, 4) Women's Health, 5) Primary Care for Adults, 6) Behavioral Health, and 7) Member Experience and Satisfaction With Health Benefit Plan], Maryland's health benefit plans demonstrate excellent performance on several measures within three categories:

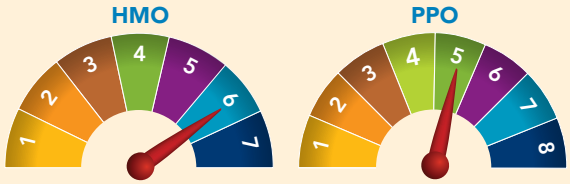
1. In the category **Primary Care and Wellness for Children and Adolescents**, the results show that health benefit plans are focusing on services to children and adolescents. Newborns are being provided the required number of well-child visits before they turn 15 months old, plus children 3 to 6 years of age and adolescents 12 to 21 years of age receive at least one well-child visit each year. The results also show that the majority of plans ensure children receive access to care and adequate preventive health care through appropriate vaccination.

NOTE: Maximum score is 7 for the HMOs and authorized HMO combination health benefit plans and 8 for the PPOs and authorized PPO combination health benefit plans.

Number of Maryland Health Benefit Plans Performing Better Than the National Average Benchmark

Primary Care and Wellness for Children and Adolescents

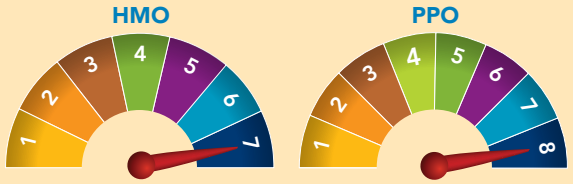
Well-Child Visits in the First 15 Months of Life – 6+ Well-Child Visits



Children who during their first 15 months of life had 6+ office visits with their primary care provider

See details on page 61

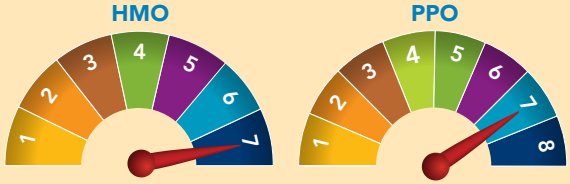
Adolescent Well-Care Visits



Adolescents aged 12 to 21 years who had at least one well-child visit with their primary care provider during 2013

See details on page 65

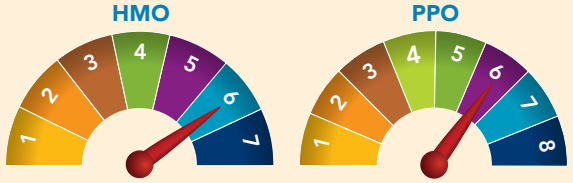
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life



Children 3, 4, 5, or 6 years of age who had at least one well-child visit with their primary care provider during 2013

See details on page 63

Childhood Immunization Status – 10 Required Immunizations



Number of children who received all of their required vaccines before they turned 2 years old (immunization/vaccination schedule based on the American Academy of Pediatrics)

See details on page 64

Maryland's health benefit plans are maintaining a track record of good performance across many of the measures and indicators being evaluated.

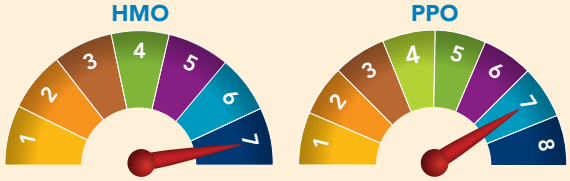
2. In the category **Child Respiratory Conditions**, the results show that health benefit plans are appropriately using strep testing to diagnose and treat children with pharyngitis.
3. In the category **Women's Health**, the results show that the majority of the health benefit plans are appropriately screening women for breast cancer and cervical cancer, plus screening for Chlamydia infection which can lead to infertility if left untreated.

NOTE: Maximum score is 7 for the HMOs and authorized HMO combination health benefit plans and 8 for the PPOs and authorized PPO combination health benefit plans.

Number of Maryland Health Benefit Plans Performing Better Than the National Average Benchmark

Child Respiratory Conditions

Appropriate Testing for Children with Pharyngitis

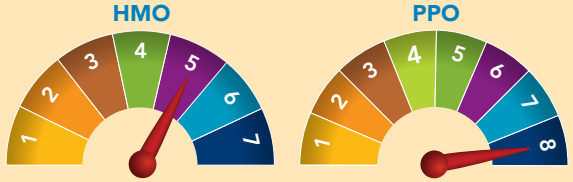


Children who received appropriate testing when diagnosed with pharyngitis during 2013

See details on page 74

Women's Health

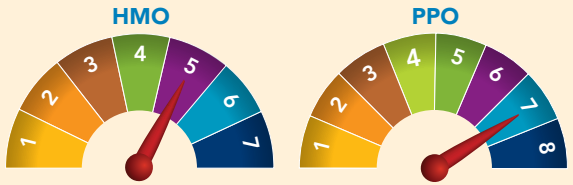
Breast Cancer Screening



The number of women aged 50 to 74 years who had a mammogram over a 27 month period of time while enrolled in the plan

See details on page 87

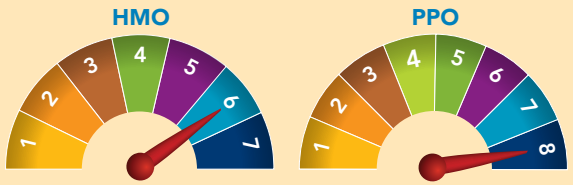
Cervical Cancer Screening



The number of women aged 21 to 64 years who had a pap smear test or appropriate screening over the appropriate period of time while enrolled in the plan

See details on page 88

Chlamydia Screening in Women



The number of women aged 16 to 24 years appropriately identified as requiring a Chlamydia test during the measurement year

See details on page 89

II. OVERVIEW

Areas for Improvement

Overall, the health benefit plans continue to perform well when compared to the national average. However, there are several items within five out of the seven categories of measures and indicators previously listed [1) Carrier Disparities Initiatives, 2) Primary Care and Wellness for Children and Adolescents, 3) Child Respiratory Conditions, 4) Women's Health, 5) Primary Care for Adults, 6) Behavioral Health, and 7) Member Experience and Satisfaction With Health Benefit Plan], where Maryland's health benefit plans demonstrate poor performance and improvement is needed on several measures within five categories.

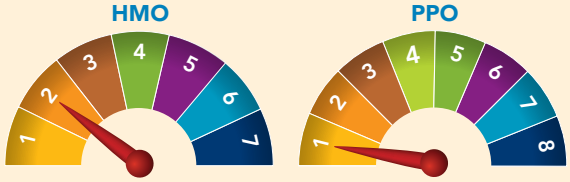
1. In the category **Primary Care and Wellness for Children and Adolescents**, the results show that health benefit plans need to focus more on conducting human papillomavirus vaccination for female adolescents and on providing appropriate follow-up care for children prescribed Attention Deficit Hyperactivity Disorder (ADHD) medication.

NOTE: Maximum score is 7 for the HMOs and authorized HMO combination health benefit plans and 8 for the PPOs and authorized PPO combination health benefit plans.

Number of Maryland Health Benefit Plans Performing Better Than the National Average Benchmark

Primary Care and Wellness for Children and Adolescents

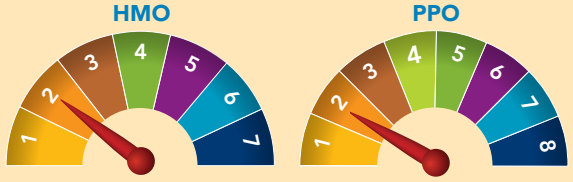
Human Papillomavirus Vaccine for Female Adolescents



Female adolescents, who turned 13 years and received the complete vaccination for human papillomavirus during 2013

See details on page 67

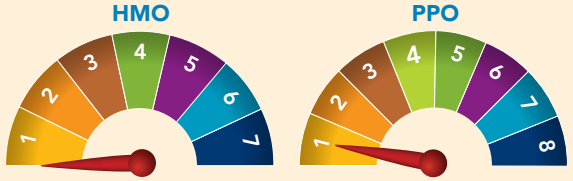
Follow-Up Care for Children Prescribed ADHD Medication – Initiation Phase



The number of children aged 6 to 12 years that were newly prescribed ADHD medication who had one follow-up visit within 30 days of diagnosis

See details on page 71

Follow-Up Care for Children Prescribed ADHD Medication – Continuation and Maintenance Phase



The number of children aged 6 to 12 years that were newly prescribed ADHD medication, remained on the medication for at least 210 days, and who had at least two additional follow-up visits between 30-270 days (9 months) of diagnosis

See details on page 72

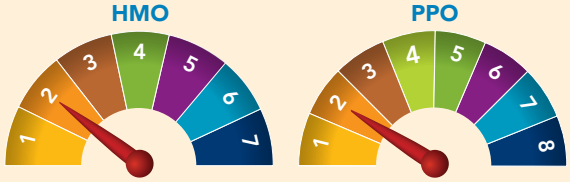
2. In the category **Child Respiratory Conditions**, the results show that health benefit plans need to improve care for children with asthma, particularly in the use of appropriate medication.
3. In the category **Women's Health**, the results show that many health benefit plans need to improve the care that is being provided to child-bearing women, as timely prenatal or postpartum services are necessary for the optimal health of mother and baby.

NOTE: Maximum score is 7 for the HMOs and authorized HMO combination health benefit plans and 8 for the PPOs and authorized PPO combination health benefit plans.

Number of Maryland Health Benefit Plans Performing Better Than the National Average Benchmark

Child Respiratory Conditions

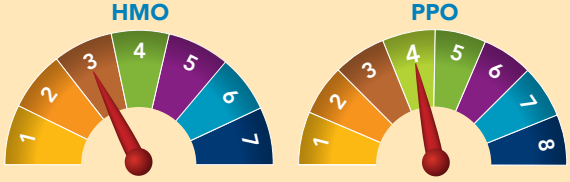
Use of Appropriate Medications for Children with Asthma (5–11 years)



Children 5 to 11 years of age who received appropriate medication for asthma during 2013

See details on page 76

Use of Appropriate Medications for Children with Asthma (12–18 years)

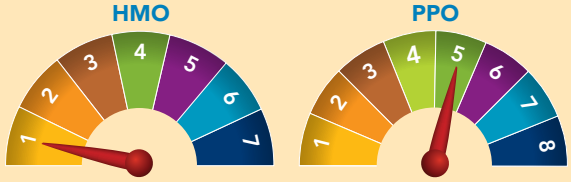


Children 12 to 18 years of age who received appropriate medication for asthma during 2013

See details on page 77

Women's Health

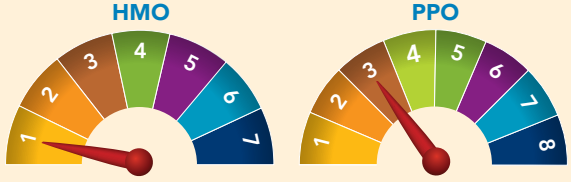
Prenatal and Postpartum Care – Timeliness of Prenatal Care



The number of women with a live birth who had a prenatal visit in their first trimester or within 42 days of enrollment

See details on page 85

Prenatal and Postpartum Care – Timeliness of Postpartum Care



The number of women with a live birth who had an appropriate follow-up visit between 21 to 56 days after delivery

See details on page 86

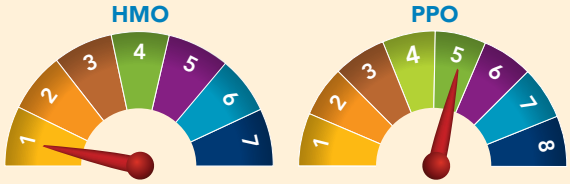
4. In the category **Primary Care for Adults**, the results show that health benefit plans have room to improve by not routinely prescribing antibiotics for acute bronchitis when perhaps antibiotics are unnecessary. Improvement is also warranted for avoiding the unnecessary use of x-rays and other imaging studies for members diagnosed with low back pain, as well as for appropriately prescribing disease-modifying anti-rheumatic drugs for members diagnosed with rheumatoid arthritis. In addition, health benefit plans need to improve cardiovascular care by controlling blood pressure among members diagnosed with hypertension and in applying persistent beta-blocker treatment for members diagnosed with a heart attack.

NOTE: Maximum score is 7 for the HMOs and authorized HMO combination health benefit plans and 8 for the PPOs and authorized PPO combination health benefit plans.

Number of Maryland Health Benefit Plans Performing Better Than the National Average Benchmark

Primary Care for Adults

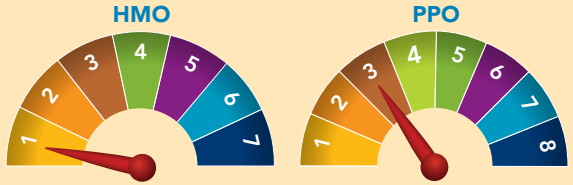
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis



Adults with acute bronchitis who were not prescribed antibiotics unless they were needed

See details on page 97

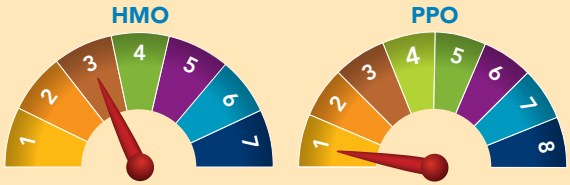
Controlling High Blood Pressure



Adults who had blood pressure appropriately controlled after initial diagnosis of hypertension

See details on page 112

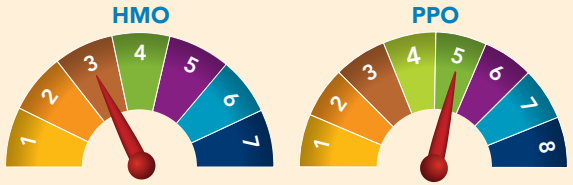
Use of Imaging Studies for Low Back Pain



The number of adults aged 18 to 50 years with low back pain that did not receive imaging studies within 28 days after diagnosis

See details on page 126

Persistence of Beta-Blocker Treatment After a Heart Attack



The number of adults aged 18 years and over who had received appropriate beta-blocker treatment after being discharged from the hospital following a heart attack

See details on page 113

Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis

The number of adults aged 18 years and over who received appropriate anti-rheumatic drug therapy after being diagnosed with rheumatoid arthritis

See details on page 125

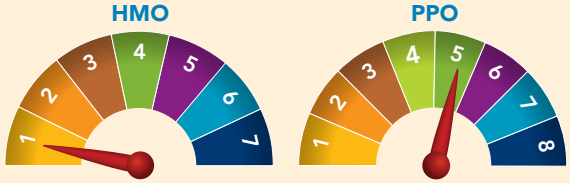
5. In the category **Behavioral Health**, the results show that improvement is needed when it comes to providing appropriate follow-up care during both the initial and continuing phases of treatment after being discharged from the hospital due to a mental health disorder.

NOTE: Maximum score is 7 for the HMOs and authorized HMO combination health benefit plans and 8 for the PPOs and authorized PPO combination health benefit plans.

Number of Maryland Health Benefit Plans Performing Better Than the National Average Benchmark

Behavioral Health

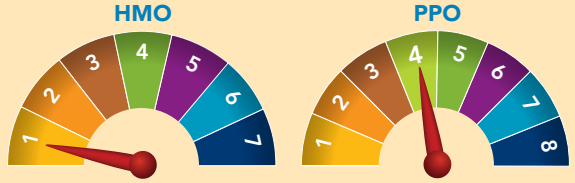
Follow-Up After Hospitalization for Mental Illness – Follow-Up Within 7 Days of Discharge



Members who had follow-up within 7 days of discharge from the hospital for a mental health disorder

See details on page 134

Follow-Up After Hospitalization for Mental Illness – Follow-Up Within 30 Days of Discharge



Members who had follow-up within 30 days of discharge from the hospital for a mental health disorder

See details on page 135

III. HEALTH BENEFIT PLAN INFORMATION

Health Benefit Plan Delivery Systems

Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Point-of-Service Organization (POS), and Exclusive Provider Organization (EPO) plans all have distinct features. Both HMO and POS plans use a Primary Care Provider (PCP), who is within the network and responsible for coordinating a patient's care. Traditionally, a key difference among HMO, PPO, and POS plans is that PPO and POS plan members do not need a referral from a PCP to see a specialist and may select a provider who is not in the plan's network of providers—although members' out-of-pocket costs are lower when they use an in-network provider.

Some employers have begun to offer EPO plans. An EPO is a relatively new type of hybrid health benefit plan with features of both an HMO and a PPO. There is usually no designated primary care provider and usually no need to obtain a referral for services with an EPO. Benefits are available for in-network office visits and hospital care, including inpatient and outpatient surgery; however, there is no coverage for out-of-network services.

Features of the Various Types of Health Benefit Plan Delivery Systems

Topic		HMO	POS	PPO	EPO
Primary Care Providers (PCPs)		Members must choose an in-network PCP to manage their care. For some plans the PCP and all medical personnel work directly for the HMO at one of its medical facilities, so it is necessary to live or work in close proximity to the medical facility(ies).	Depending on the plan, members may need to choose an in-network PCP to manage their care.	Members are not required to have a PCP to manage their care. Members may choose an in-network PCP or out-of-network PCP to manage their care.	Depending on the plan, members may need to choose an in-network PCP to manage their care.
Referrals to specialty care providers		Members need a referral from their PCP to see a specialist and other providers, although some HMOs no longer require referrals.	Referrals may be needed to seek care from specialists or other providers. Members may choose between PCP referral to an in-network specialist or they may choose to see an out-of-network specialist.	No referrals are needed to seek care from specialists or other health care providers. Other than physician office visits and emergency care, services must usually be authorized by the PPO before members receive them.	Referrals may be needed to seek care from specialists or other in-network providers. Members must choose in-network providers if they have a need for a specialist. Some plans may allow referrals to out-of-network providers in emergency situations.
Out-of-pocket costs	**Annual premiums**	Annual premiums tend to be lower than POS and PPO plans.	Annual premiums tend to fall between HMO and PPO plans.	Annual premiums tend to be higher than HMO and POS plans.	Annual premiums tend to be lower than PPO plans.
	Cost sharing	*Cost sharing:* Fixed co-payments with no annual deductible or coinsurance. As long as you see your PCP or have an authorized referral to another provider, your out-of-pocket cost is usually a relatively small copayment per visit. But if you choose to go to another provider without a referral—whether or not the providers are in the HMO network—you'll have to pay 100% of the provider's bills. The exceptions are true emergency situations for which you are covered by the plan.	*Cost sharing:* Fixed co-payments for in-network services; deductibles and coinsurance may apply to in-network services and out-of-network services; higher costs associated with out-of-network services. You pay least when you receive services from your PCP or through an authorized referral to another in-network provider. But unlike an HMO, you may opt out of the network. If you opt out you'll be responsible for paying a higher percent of the provider's bill.	*Cost sharing:* Fixed co-payments for in-network services; deductibles and coinsurance may apply to in-network services and out-of-network services. A PPO plan encourages you to choose doctors, hospitals, and other providers that participate in the plan. They do this by increasing the portion of the bill they pay if you stay "in-network." You may choose to go "out-of-network" at any time, but if you do, you'll have to pay a higher percent of the provider's bill.	*Cost sharing:* Fixed co-payments for in-network services; deductibles and coinsurance may apply to in-network services and out-of-network services, if allowed. In choosing an EPO, it is important to make sure that the program includes enough providers to match your needs. In most EPO plans, as with an HMO, if you choose to go out-of-network, you'll have to pay 100% of the provider's bills.

Sources: Maryland Department of Budget and Management, Health Benefits; National Association of Insurance Commissioners; and Healthcare.gov

III. HEALTH BENEFIT PLAN INFORMATION

Maryland Health Benefit Plans Reporting in 2014

Abbreviated health benefit plan report-level names are used in this report.

Maryland Health Benefit Plans Reporting in 2014				
Report-Level Name	**Health Plan Name**	**Product Type**	**Contact Information**	**Tax Status and Ownership**
Aetna (HMO)	Aetna Health, Inc. (Pennsylvania) – Maryland	HMO/POS Combined	1-800-US-AETNA (1-800-872-3862) 7 days a week, 7:00 AM–7:00 PM **www.aetna.com**	Aetna is a for-profit HMO with POS, PPO and EPO.
Aetna (PPO)	Aetna Life Insurance Company (MD/DC)	PPO/EPO Combined		
CareFirst BlueChoice (HMO)	CareFirst BlueChoice, Inc.	HMO/POS Combined	1-888-432-4380 7 days a week, 7:00 AM–7:00 PM **www.carefirst.com**	CareFirst BlueChoice is a for-profit HMO.
CareFirst GHMSI (PPO)	Group Hospitalization and Medical Services, Inc. (GHMSI)	PPO		GHMSI is a not-for-profit PPO.
CareFirst CFMI (PPO)	CareFirst of Maryland, Inc.	PPO/EPO Combined		CareFirst of Maryland, Inc. is a not-for-profit PPO with EPO.
Cigna (PPO)	Cigna Health and Life Insurance Company/ Connecticut General Life Insurance Company	POS/PPO Combined	1-866-GET-Cigna (1-866-438-2446) 24 hours a day, 7 days a week **www.cigna.com**	Connecticut General Life Insurance Company is doing business as Cigna and is a for-profit POS and PPO.
Coventry (HMO)	Coventry Health Care of Delaware, Inc.	HMO/POS Combined	1-800-833-7423 Monday–Friday, 8:00 AM–5:00 PM **www.coventryhealthcare.com**	Coventry Health Care of Delaware, Inc. is a for-profit HMO and has a for-profit PPO offered by Coventry Health and Life Insurance Company.
Coventry (PPO)	Coventry Health and Life Insurance Company	PPO		
Kaiser Permanente (HMO)	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	HMO/POS Combined	1-800-245-3181 24 hours a day, 7 days a week **www.kaiserpermanente.org**	Each independent Kaiser Permanente Medical Group in Maryland operates as a separate for-profit HMO plan and is primarily funded by reimbursements from the Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
KPIC (PPO)	Kaiser Permanente Insurance Company	POS		Kaiser Permanente Insurance Company is a for-profit POS.

continued

Maryland Health Benefit Plans Reporting in 2014

Abbreviated health benefit plan report-level names are used in this report.

Maryland Health Benefit Plans Reporting in 2014 continued				
Report-Level Name	**Health Plan Name**	**Product Type**	**Contact Information**	**Tax Status and Ownership**
MD-IPA (HMO)	(UnitedHealthcare) Maryland Individual Practice Association, Inc.	HMO/POS Combined	1-800-307-7820 TTY: 711 (Maryland only) 24 hours a day, 7 days a week **www.myuhc.com**	MD–IPA and Optimum Choice, for-profit HMOs, are owned and operated by a regional holding company and are subsidiaries of UnitedHealth Group, Inc.
Optimum Choice (HMO)	(UnitedHealthcare) Optimum Choice, Inc.	HMO/POS Combined		
UnitedHealthcare (HMO)	UnitedHealthcare of the Mid-Atlantic, Inc.	HMO	1-800-307-7820 TTY: 711 (Maryland only) 24 hours a day, 7 days a week **www.uhc.com**	UnitedHealthcare of the Mid-Atlantic, Inc. is a for-profit HMO plan and a subsidiary of United-Health Group, Inc.
MAMSI (PPO)	(UnitedHealthcare) MAMSI Life and Health Insurance Company	PPO		UnitedHealthcare Insurance Company (Maryland) and MAMSI Life and Health Insurance Company are both for-profit PPO plans and subsidiaries of UnitedHealth Group, Inc.
UnitedHealthcare (PPO)	UnitedHealthcare Insurance Company (Maryland)	PPO/POS/EPO Combined		

III. HEALTH BENEFIT PLAN INFORMATION

Managed Behavioral Health Care Organizations (MBHOs)

Behavioral health care services include mental health services as well as services for mood, behavioral, and addictive disorders such as the abuse of alcohol or other substances. Behavioral health care services are provided through the health benefit plan's own provider network or through a contractual arrangement with a behavioral health care services vendor. Members have access to these services based on the benefits package linked to their contract. These charts provide information on who is providing the behavioral health care services for each health benefit plan.

Report Level Name of MBHO Providing Behavioral Health Care Services	
HMO	**Name of MBHO**
Aetna	Aetna Behavioral Health Pennsylvania
CareFirst BlueChoice	Magellan Health Services
Coventry	MHNet Behavioral Health
Kaiser Permanente	Kaiser Permanente Health Plan of the Mid-Atlantic States
MD-IPA	United Behavioral Health
Optimum Choice	United Behavioral Health
UnitedHealthcare	United Behavioral Health
PPO	**Name of MBHO**
Aetna	Aetna Behavioral Health Pennsylvania
CareFirst GHMSI	CareFirst's regional provider network; Magellan Health Services – for utilization and care management services
CareFirst CFMI	
Cigna	Cigna Behavioral Health, Inc.
Coventry	MHNet Behavioral Health
KPIC	Kaiser Permanente Health Plan of the Mid-Atlantic States
MAMSI	United Behavioral Health
UnitedHealthcare	United Behavioral Health

III. HEALTH BENEFIT PLAN INFORMATION

Behavioral Health Care Providers in Maryland

Total Behavioral Health Care Providers (Maryland)												
HMO	Psychiatrists	Physicians, Certified in Addiction Medicine	Psychologists	Social Workers	Licensed Social Work Associates	Nurse Psychotherapists	Nurse Practitioners	Registered Nurses	Licensed Therapists and Counselors	Alcohol and Drug Counselors	Other Professional Titles: Applied Behavioral Analysts – Autism Treatment	All Professionals (TOTAL)
Aetna	556	1	427	1,309	0	96	0	0	755	23	0	3,167
CareFirst BlueChoice	542	0	514	1,712	0	166	1,475	0	1,043	0	0	5,452
Coventry	270	0	149	539	0	0	28	0	291	0	0	1,277
Kaiser Permanente	353	1	267	473	0	27	9	0	153	5	0	1,288
MD-IPA	454	4	470	1,036	0	114	12	0	435	0	0	2,525
Optimum Choice	454	4	470	1,036	0	114	12	0	435	0	0	2,525
UnitedHealthcare	442	4	459	1,022	0	113	12	0	432	0	0	2,484
PPO												
Aetna	571	1	432	1,342	0	104	0	0	770	24	0	3,244
CareFirst GHMSI	1,167	0	964	2,400	0	95	1,678	0	1,215	1	0	7,520
CareFirst CFMI	1,167	0	964	2,400	0	95	1,678	0	1,215	1	0	7,520
Cigna	353	10	274	796	0	66	0	0	443	10	13	1,965
Coventry	270	0	149	539	0	0	28	0	291	0	0	1,277
KPIC	630	1	531	919	0	27	9	0	387	8	0	2,512
MAMSI	454	4	470	1,036	0	114	12	0	435	0	0	2,525
UnitedHealthcare	454	4	470	1,036	0	114	12	0	435	0	0	2,525

Data Source: HEDIS® Submission, Maryland Plan BHA Submission or Health Benefit Plan Records

III. HEALTH BENEFIT PLAN INFORMATION

Health Benefit Plan Accreditation Information

Accreditation is another way of assessing health benefit plan quality and performance via an independent, external assessment of quality and performance by a review organization. National Committee for Quality Assurance (NCQA), URAC (formerly known as the Utilization Review and Accreditation Commission) and Accreditation Association of Ambulatory Health Care (AAAHC) all accredit the health benefit plans and managed behavioral healthcare organizations (MBHOs) in this report. Each health benefit plan and MBHO in this report voluntarily obtained one or more types of accreditation through NCQA, URAC or AAAHC.

NCQA Accreditation

The NCQA accreditation program evaluates how well an organization manages its delivery system—physicians, hospitals, other providers, and administrative services—for continuous improvement of the health care it delivers to members. A team of physicians and managed care experts conducts on-site and off-site evaluations. The team reviews grievance procedures, physician evaluation and care management processes, preventive health efforts, medical record keeping, quality and performance improvement, and quality and performance on key aspects of clinical care, such as immunization rates.

NCQA assigns one of the following five accreditation levels, based on an organization's performance:

Excellent: NCQA awards its highest accreditation status of Excellent to organizations with programs for service and clinical quality and performance that meet or exceed rigorous requirements for consumer protection and quality and performance improvement. HEDIS® and CAHPS® results are in the highest range of national performance.

Commendable: NCQA awards a status of Commendable to organizations with well-established programs for service and clinical quality and performance that meet rigorous requirements for consumer protection and quality and performance improvement.

Accredited/Full: NCQA awards a status of Accredited/Full to organizations with programs for service and clinical quality and performance that meet basic requirements for consumer protection and quality and performance improvement. Organizations awarded this status must take further action to achieve a higher accreditation status.

Provisional: NCQA awards a status of Provisional to organizations with programs for service and clinical quality and performance that meet some, but not all, basic requirements for consumer protection and quality and performance improvement. Organizations awarded this status need to take significant action to improve their processes and achieve a higher accreditation status.

Interim: NCQA awards a status of Interim to organizations with basic structures and processes in place to meet expectations for consumer protection and quality improvement. Organizations awarded this status will need to undergo a new review within 18 months to demonstrate they have executed those processes effectively.

Denied: NCQA denies accreditation to organizations whose programs for service and clinical quality and performance did not meet NCQA requirements during the accreditation survey.

NCQA MBHO Accreditation

The NCQA MBHO accreditation program is closely aligned with the NCQA health benefit plan accreditation program.

The MBHO accreditation program requires MBHOs to annually monitor and evaluate at least two preventive behavioral health care screenings and educational interventions offered to their covered population. The categories of preventive interventions listed in the standards are adapted from the Institute of Medicine's *Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research* (1994). This publication lists a number of illustrative preventive interventions for the various age and population categories.

URAC Accreditation

URAC's accreditation standards provide a comprehensive assessment of organization quality and performance that applies to health care systems which provide a full range of health care services, such as HMO health benefit plans and fully integrated PPO health benefit plans. Standards include key quality and performance benchmarks for network management, provider credentialing, utilization management, quality and performance improvement, as well as consumer protection.

Organizations applying for accreditation participate in a review process involving several phases. The initial phase of the accreditation process consists of completing the application forms and supplying supporting documentation. The remaining three phases cover a period of approximately four to six months and include a desktop review phase, on-site review phase, plus a committee review phase. During the review process, the reviewer analyzes the applicant's documentation with regard to URAC standards.

URAC assigns one of the following three accreditation levels based on an organization's quality and performance:

Full: URAC awards an accreditation status of Full to organizations that successfully meet all requirements. Full accreditation is for two years. An accreditation certificate is issued to each company site that participates in the accreditation review. As a condition of accreditation, organizations awarded Full accreditation must remain compliant with URAC standards during the two-year accreditation cycle.

Conditional: URAC awards an accreditation status of Conditional to organizations that have appropriate documentation but did not completely implement certain policies or procedures before achieving full compliance. URAC requires organizations with Conditional accreditation to demonstrate full compliance and move to Full accreditation status within six months.

Provisional: URAC awards an accreditation status of Provisional to organizations that complied with all standards but had not been in operation long enough (less than six months) at the time of the onsite review to demonstrate full compliance. URAC requires organizations with Provisional accreditation to demonstrate full compliance of standards to meet Full accreditation status within six months.

Other: Organizations that cannot meet URAC standards may be placed on corrective action status, may be denied accreditation, or may withdraw.

URAC MBHO Accreditation

Like other integrated health care delivery systems, MBHOs may undergo a full review of their operations or have individual components reviewed for accreditation. URAC's accreditation standards assess an organization and assign an accreditation level based on quality and performance on defined standards. The accreditation process consists of the multi-phase review described in the previous section. A range of accreditation programs is available through URAC, permitting review of a segment of organization operations. The Health Utilization Management and Case Management standards are examples of accreditation modules that managed care plans (such as MBHOs) select to demonstrate that they have the appropriate structures and procedures to promote quality care when making medical necessity determinations.

III. HEALTH BENEFIT PLAN INFORMATION

HEALTH BENEFIT PLAN ACCREDITATION INFORMATION

AAAHC Accreditation

The Accreditation Association for Ambulatory Health Care (AAAHC) health benefit plan accreditation standards outline expectations for health benefit plans that include key areas of member rights/responsibilities/protection, governance/administration, network adequacy/credentialing, care and case management, quality improvement programs including benchmarking and risk management, clinical record-keeping, health education/promotion, and environment of care and safety. The standards highlight the expectations and requirements and include specific review guidelines that outline how the health benefit plan can ensure its ability to meet the standard.

The survey process includes submission of an application that provides details about the health benefit plan and its lines of business, an on-site evaluation of organizational processes and programs, site visits to selected provider locations determined in conjunction with the health benefit plan to showcase delivery processes, and committee evaluation to determine accreditation status.

Each accreditation survey is tailored to the type, complexity, and range of services offered by the organization seeking accreditation. The five types of accreditation surveys include the following:

Initial Accreditation Surveys: Initial accreditation surveys are conducted for organizations that are not currently accredited by AAAHC.

Re-Accreditation Surveys: Re-accreditation surveys are conducted for organizations that are currently AAAHC-accredited and seek continuation of accreditation.

Interim Surveys: Interim surveys are conducted for organizations that are currently AAAHC-accredited and for which oversight is required to assess ongoing compliance with the accreditation standards. The organization will be informed of the need for an interim survey following review of the Plan for Improvement.

Random Surveys: To support ongoing AAAHC quality improvement initiatives, an accredited organization may be selected for a random survey from nine to thirty months after an accreditation survey. Organizations are selected to participate in unannounced random surveys on a proportionate basis across settings and geographic areas.

Discretionary Surveys: Discretionary surveys are conducted "for cause," when concerns have been raised about an accredited organization's continued compliance with the standards. An accredited organization may undergo a discretionary survey at any time, without advance notice, and at the discretion of AAAHC.

The length of the on-site visit and the number of surveyors sent to conduct an accreditation survey is based on size of health benefit plan membership, the number of lines of business, and a review of the information provided in the Application for Survey and supporting documents submitted by the organization. Plans meeting all AAAHC accreditation standards will be awarded a three-year accreditation certificate. At any time during this three year period, the accreditation status can be revoked or revised based on the results from an interim, random or discretionary survey that may occur.

Full Accreditation: AAAHC awards a Full Accreditation status for a period of three years to organizations that successfully meet all requirements.

Provisional Accreditation: AAAHC awards a Provisional Accreditation status to any organization that fails to meet all minimum requirements for accreditation. Any organization with a Provisional Accreditation is required to comply with a follow-up survey that includes an additional on-site evaluation. The follow up survey is required either six months or one year after the initial survey. A Plan For Improvement (PFI) may be required from the health benefit plan.

AAAHC MBHO Accreditation

The AAAHC health plan accreditation program provides for accreditation of behavioral health plans and dental health plans through the application of additional specific behavioral health or dental standards and review guidelines. AAAHC's evaluation process evaluates the MBHO's performance based on five levels (fully, substantially, partially, minimally, and non-compliant) and accreditation awards include fully accredited or accredited with a required PFI and follow-up survey. Plans meeting all AAAHC accreditation standards will be awarded a three-year accreditation certificate. At any time during this three year period, the accreditation status can be revoked or revised based on the results from an interim, random or discretionary survey that may occur.

III. HEALTH BENEFIT PLAN INFORMATION

HEALTH BENEFIT PLAN ACCREDITATION INFORMATION

Health Benefit Plan Accreditation Status								
HMO	**Organization**	**Accreditation Status**	**Expiration Year**	**Name of MBHO or Accredited Segment of Health Benefit Plan**	**NCQA MBHO Accreditation Status: Expiration Year**	**URAC Health Utilization Management Accreditation**	**URAC Case Management Accreditation**	**AAAHC Accreditation**
Aetna	NCQA	Commendable	2014	Aetna Behavioral Health Pennsylvania	Full; 2016	–	–	–
CareFirst BlueChoice	NCQA	Commendable	2014	Magellan Tristate Care Management Center	Full; 2016	Full; 2016	Full; 2016	–
Coventry	URAC	Full Accreditation	2014	MHNet Behavioral Health	Full; 2015	Full; 2015	–	–
Kaiser Permanente	NCQA	Excellent	2016	Kaiser Permanente Health Plan of the Mid-Atlantic States	Excellent; 2016	–	–	–
MD-IPA	NCQA	Commendable	2015	United Behavioral Health	Full; 2017	Full; 2017	–	–
Optimum Choice	NCQA	Commendable	2015	United Behavioral Health	Full; 2017	Full; 2017	–	–
UnitedHealthcare	NCQA	Commendable	2015	United Behavioral Health	Full; 2017	Full; 2017	–	–
PPO								
Aetna	NCQA	Commendable	2014	Aetna Behavioral Health Pennsylvania	Full; 2016	–	–	–
CareFirst GHMSI	NCQA	Commendable	2014	Magellan Tristate Care Management Center	Full; 2016	Full; 2016	Full; 2016	–
CareFirst CFMI	NCQA	Commendable	2014	Magellan Tristate Care Management Center	Full; 2016	Full; 2016	Full; 2016	–
Cigna	NCQA	Commendable	2014	Cigna Behavioral Health, Inc	Full; 2014	–	–	–
Coventry	URAC	Full Accreditation	2014	MHNet Behavioral Health	Full; 2015	Full; 2015	–	–
KPIC	NCQA	Excellent	2016	Kaiser Permanente Health Plan of the Mid-Atlantic States	Excellent; 2016	–	–	–
MAMSI	NCQA	Commendable	2015	United Behavioral Health	Full; 2017	Full; 2017	–	–
UnitedHealthcare	NCQA	Commendable	2015	United Behavioral Health	Full; 2017	Full; 2017	–	–

Data Source: HEDIS® Submission or Health Benefit Plan Records

III. HEALTH BENEFIT PLAN INFORMATION

Health Benefit Plan Board and State Certification Status

Board and State Certification Status of Provider Network*								
HMO	Family Medicine	Internal Medicine	OB/GYN Physicians	Pediatricians	Geriatricians	Psychiatrists	Other Physician Specialists (non BH)	Behavioral Health Specialists (non MD)
Aetna	80.2%	77.2%	73.1%	86.4%	66.7%	79.5%	73.1%	82.4%
CareFirst BlueChoice	80.5%	84.2%	66.4%	84.0%	78.3%	76.6%	68.8%	90.1%
Coventry	70.9%	72.7%	70.7%	82.6%	66.7%	30.4%	74.2%	78.9%
Kaiser Permanente	87.8%	83.5%	83.9%	92.4%	97.9%	88.1%	88.4%	74.9%
MD-IPA	76.4%	79.1%	85.1%	87.0%	68.8%	81.5%	83.1%	82.0%
Optimum Choice	76.4%	79.1%	85.1%	87.0%	83.1%	81.5%	83.1%	82.0%
UnitedHealthcare	65.0%	75.3%	85.9%	86.1%	66.7%	81.5%	83.0%	82.2%
PPO								
Aetna	81.6%	77.2%	74.1%	85.2%	62.4%	77.2%	72.3%	82.4%
CareFirst GHMSI	79.1%	83.1%	64.5%	84.0%	77.5%	57.9%	68.0%	84.5%
CareFirst CFMI	79.1%	83.1%	64.5%	84.0%	77.5%	57.9%	68.0%	84.5%
Cigna	72.0%	79.3%	48.5%	74.0%	69.8%	73.7%	70.4%	81.4%
Coventry	70.9%	72.7%	70.7%	82.6%	66.7%	30.4%	74.2%	78.9%
KPIC	85.6%	83.7%	82.3%	87.4%	92.3%	85.4%	84.2%	72.6%
MAMSI	76.4%	79.1%	85.1%	86.9%	68.8%	81.5%	83.1%	82.0%
UnitedHealthcare	76.3%	79.0%	85.3%	87.0%	68.4%	81.5%	83.2%	82.0%

* Percentage of Board and State Certified Providers – a provider who is board or State certified and credentialed to work in multiple disciplines will be counted in each relevant discipline in the chart.

Data Source: HEDIS® Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Health Care Disparities

According to the Kaiser Family Foundation, "One in three residents of the United States self-identify as either African American, American Indian/Alaska Native, Asian, Native Hawaiian/Pacific Islander, Hispanic/Latino, or multiracial. By 2050, this number is expected to increase to one in two. Despite significant advances…race remains a significant factor in determining whether an individual receives care, whether an individual receives high-quality care, and in determining health outcomes." Recent research has indicated that disparities in health care can be effectively addressed through appropriate language-based approaches. Health benefit plans are expected to determine by direct means the racial and cultural make up of their members and have diverse approaches to meeting the cultural and language needs of their members.

http://kff.org/disparities-policy/issue-brief/eliminating-racialethnic-disparities-in-health-care-what/

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Background to Maryland Demographics

Share of State Population

Maryland ranks nineteenth nationally in terms of population, with approximately 5.9 million people. Over 82% of State residents live centrally within the Baltimore and National Capital regions.

The 24 jurisdictions, including 23 Maryland counties and the jurisdiction of Baltimore City, are divided into the following five regions:

Western Maryland – Garrett, Allegany and Washington counties

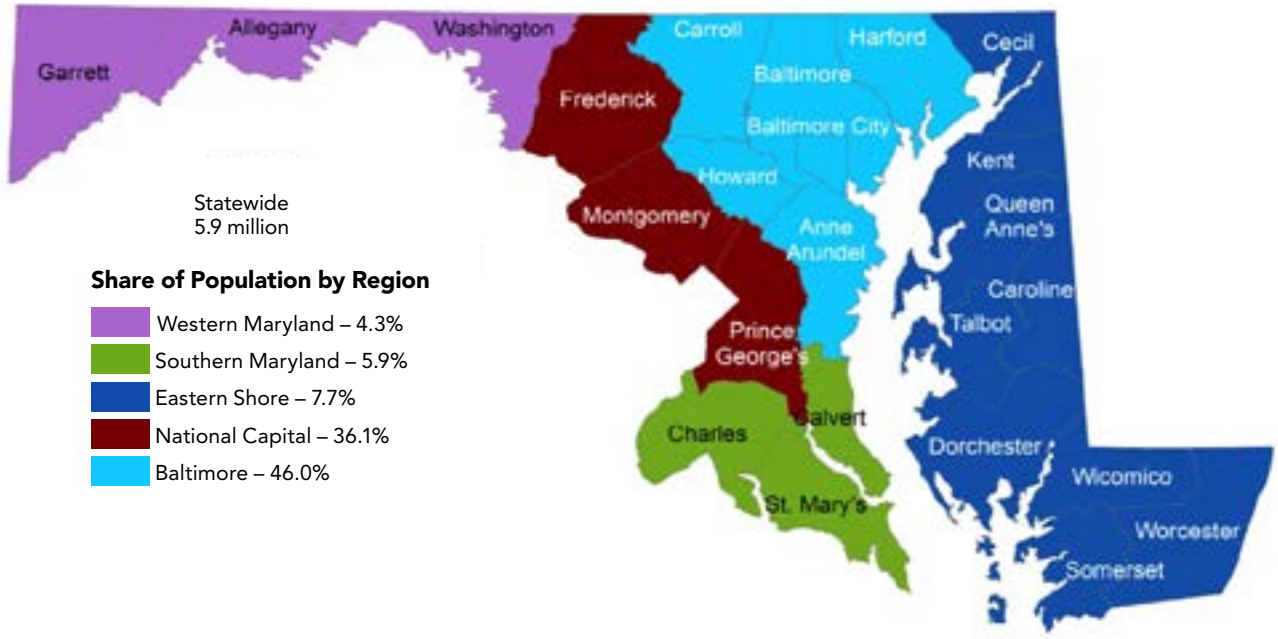
Southern Maryland – Calvert, Charles and St. Mary's counties

Eastern Shore – Cecil, Kent, Queen Anne's, Caroline, Talbot, Dorchester, Wicomico, Worcester, and Somerset counties

National Capital – Frederick, Montgomery and Prince George's counties

Baltimore – Carroll, Howard, Anne Arundel, Baltimore, and Harford counties and Baltimore City

Share of Population by Region (2012)



Prepared by: Maryland Department of Legislative Services
Source: U.S. Census Bureau
Updated: December 2, 2013

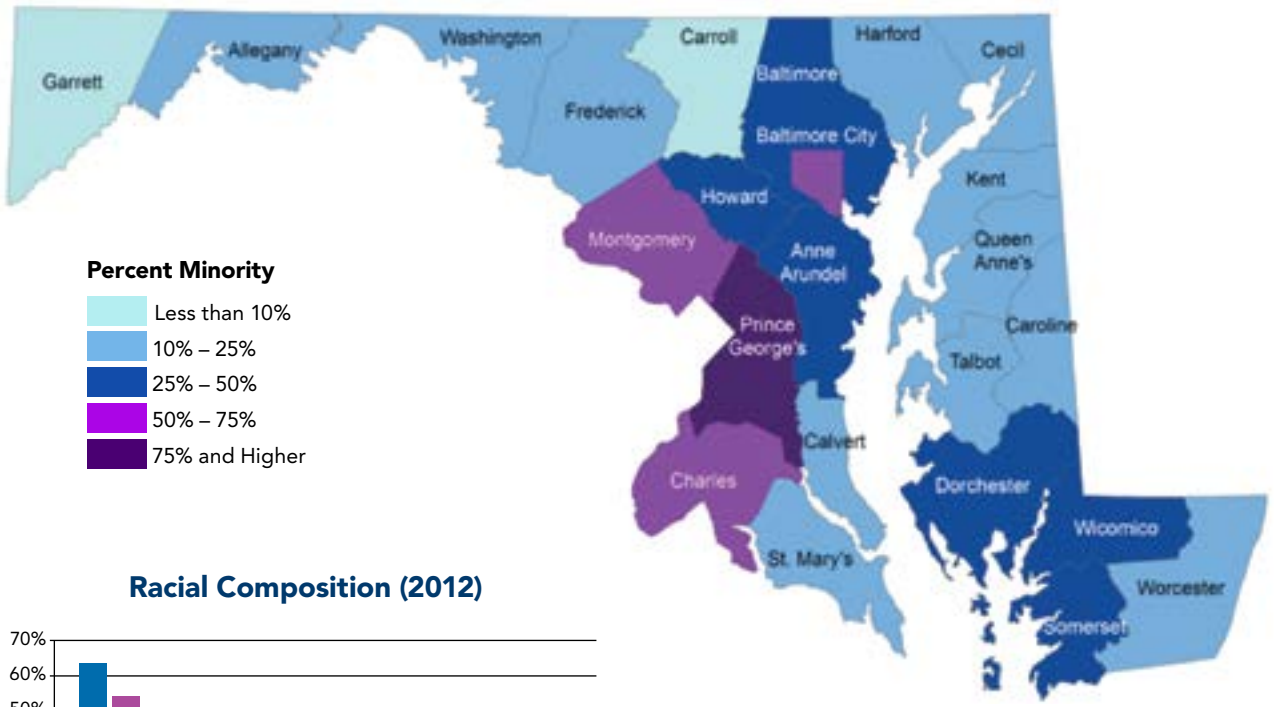
Maryland Racial Composition

Four of Maryland's jurisdictions have a majority minority population; they are Baltimore City, as well as Montgomery, Prince George's and Charles counties.

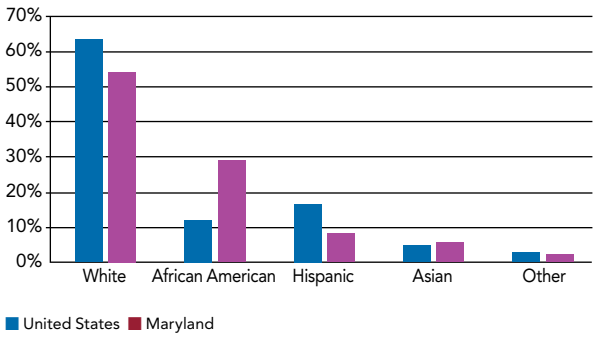
Racial minorities comprise 46.1% of the State's population compared to 36.6% nationally.

African Americans are the largest racial minority in Maryland comprising 29.1% of the State's population; whereas Hispanics account for 8.7%, followed by Asians at 5.9%.

Racial Composition by County – All Ages (2012)



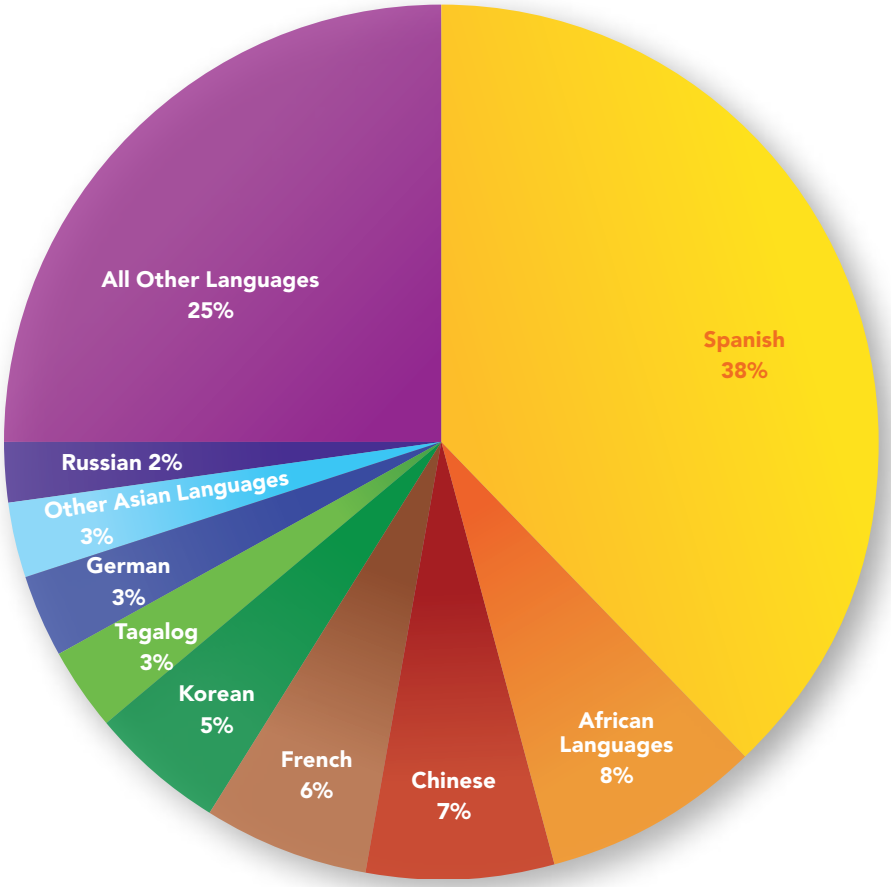
Racial Composition (2012)



Prepared by: Maryland Department of Legislative Services
Source: U.S. Census Bureau
Updated: December 2, 2013

Languages Spoken at Home, Other than English (2012)

Maryland remains one of the most diverse states with people from approximately 160 different countries speaking over one hundred languages. Nationally, Maryland has the tenth highest percentage of residents who are foreign-born. 13.8% of Maryland residents are foreign-born compared to 12.9% at the national level.



Prepared by: Maryland Department of Legislative Services
Source: U.S. Census Bureau
Updated: December 2, 2013

Language	Number of speakers	Spoke English less than "Very Well"
Spanish	299,225	47.7%
African languages	60,515	23.3%
Chinese	54,869	51.1%
French	47,573	26.0%
Korean	38,832	54.1%
Tagalog	24,686	29.4%
German	21,988	14.8%
Other Asian Languages	20,549	27.6%
Russian	19,102	50.8%
Other Indic languages	17,038	32.8%
Vietnamese	16,813	61.9%
Hindi	14,424	17.0%
Arabic	13,292	24.8%
Italian	11,664	23.1%
Urdu	11,594	31.4%
Greek	11,476	26.0%
French Creole	11,269	25.4%
Persian	11,075	38.2%
Other Indo-European languages	10,034	28.7%
Portuguese	9,355	45.5%
Hebrew	7,953	9.7%
Gujarati	7,669	38.0%
Japanese	6,669	47.6%
Polish	5,346	32.6%
Other Slavic languages	4,712	36.2%
Other Pacific Island languages	4,344	49.4%
Thai	3,308	47.3%
Hungarian	2,144	30.1%
Scandinavian languages	2,140	13.6%
Mon-Khmer, Cambodian	1,916	42.8%
Other and unspecified languages	1,639	34.2%
Serbo-Croatian languages	1,474	20.4%
Armenian	1,292	35.3%
Yiddish	1,252	19.0%
Other Native North American languages	854	14.3%
Laotian	787	54.5%
Navajo	62	16.1%

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Carrier Disparities Initiatives

aetna

Quality, culturally competent care improves health outcomes for minority populations and decreases the waste that drives cost up. That's why Aetna took a leadership position in 2001 and launched a strategic initiative to reduce racial and ethnic disparities in health care, with a goal to improve access to quality health care services for all members. Aetna's approach includes a variety of preventive and educational activities. Race, ethnicity and language preference information voluntarily provided by members help to identify the best opportunities for targeted activities that improve quality of care. Examples include improving mammography screening for at risk minority populations, reducing premature labor in African American women, and improving asthma care in African American and Hispanic members.

HMO	
Provider Specialty	**Number of Plan Providers in Maryland**
Family Medicine	2,699
Internal Medicine	6,415
OB/GYN Physicians	2,461
Pediatricians	2,346
Geriatricians	146
Psychiatrists	855
Other Physician Specialists (non-Behavioral Health)	34,886
Behavioral Health Specialists (non-MD)	3,873
Board Certified	**Number of Plan Providers in Maryland**
Yes	38,974
No	14,707

PPO	
Provider Specialty	**Number of Plan Providers in Maryland**
Family Medicine	2,820
Internal Medicine	6,535
OB/GYN Physicians	2,524
Pediatricians	2,423
Geriatricians	167
Psychiatrists	872
Other Physician Specialists (non-Behavioral Health)	35,207
Behavioral Health Specialists (non-MD)	3,947
Board Certified	**Number of Plan Providers in Maryland**
Yes	39,436
No	15,059

Data Source: Maryland Plan BHA Submission, Maryland Health Plan QP Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

CARRIER DISPARITIES INITIATIVES

Aetna – Number of Providers by Specialty and County/Jurisdiction

Region	County/ Jurisdiction	Family Medicine		Internal Medicine		OB/GYN Physicians		Pediatricians		Geriatricians		Psychiatrists		Other Physician Specialists (non BH)		Behavioral Health Specialists (non MD)	
		HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO
Western Maryland	Allegany	1	15	13	51	6	15	3	16	2	3	0	8	30	126	4	46
	Garrett	0	19	0	4	0	0	0	0	0	2	0	1	16	36	1	5
	Washington	57	59	82	82	27	27	47	49	0	0	36	37	433	435	147	147
Southern Maryland	Calvert	19	22	79	79	28	28	18	18	1	1	9	9	692	688	84	84
	Charles	97	98	103	108	31	33	45	45	1	1	3	3	544	547	76	78
	St. Mary's	31	31	74	75	11	11	38	38	0	0	7	6	228	233	34	32
Eastern Shore	Caroline	6	18	0	2	1	2	0	1	0	0	0	0	1	2	0	2
	Cecil	47	47	23	22	16	16	19	19	0	0	7	7	143	146	70	72
	Dorchester	1	10	2	9	5	7	3	4	0	0	1	12	47	62	8	22
	Kent	4	4	18	20	6	7	2	2	0	1	0	0	246	244	13	13
	Queen Anne's	17	17	9	8	21	21	21	21	0	0	4	4	135	137	46	47
	Somerset	0	1	2	5	9	9	5	7	0	0	1	1	4	7	5	14
	Talbot	20	20	31	30	14	15	14	14	0	0	8	8	186	190	41	40
	Wicomico	8	8	52	53	37	37	33	36	0	0	14	14	258	265	72	76
	Worcester	5	32	28	35	3	7	2	4	1	1	0	3	85	103	2	24
National Capital	Frederick	107	108	93	102	84	84	160	159	2	2	37	38	968	987	176	175
	Montgomery	282	291	729	751	524	539	366	399	7	9	85	86	3,719	3,943	532	536
	Prince George's	196	202	588	607	251	263	187	187	7	11	42	43	2,522	2,640	308	303
Baltimore	Anne Arundel	461	469	571	581	205	209	259	264	9	11	46	47	3,035	3,014	412	408
	Baltimore	650	655	1,471	1,461	361	369	243	243	49	53	168	167	8,166	7,995	745	735
	Baltimore City	353	353	1,857	1,867	583	587	652	663	55	58	262	262	8,615	8,657	367	366
	Carroll	66	67	88	86	44	44	48	50	3	3	36	34	1,371	1,329	217	219
	Harford	163	166	206	209	52	53	88	91	2	2	28	28	1,762	1,748	214	212
	Howard	108	108	296	288	142	141	93	93	7	9	61	54	1,680	1,673	299	291
	Unknown	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Data Source: Maryland Plan BHA Submission, Maryland Health Plan QP Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

CARRIER DISPARITIES INITIATIVES

CareFirst

CareFirst recognizes how racial and ethnic disparities affect the outcome of patient care and, as such, has targeted those circumstances that may cause gaps in care. With a combination of direct and indirect methods, communications are centered on the languages and cultural options that may be most accessible to the patient. Through these practices, CareFirst has diversified into sub-regions to more accurately attend to specific patient considerations. This includes dedicating resources to services for those who may be uninsured or underinsured and providing improved access, safety, and services to all citizens in the community. These goals are supported by improved maternal and child health outreach programs and increased support of safety net health centers throughout Maryland.

HMO	
Provider Specialty	**Number of Plan Providers in Maryland**
Family Medicine	2,162
Internal Medicine	6,140
OB/GYN Physicians	1,573
Pediatricians	2,738
Geriatricians	256
Psychiatrists	542
Other Physician Specialists (non-Behavioral Health)	14,085
Behavioral Health Specialists (non-MD)	3,435
Board Certified	**Number of Plan Providers in Maryland**
Yes	20,570
No	10,358

PPO*	
Provider Specialty	**Number of Plan Providers in Maryland**
Family Medicine	2,331
Internal Medicine	6,312
OB/GYN Physicians	1,512
Pediatricians	2,594
Geriatricians	263
Psychiatrists	5,998
Other Physician Specialists (non-Behavioral Health)	14,297
Behavioral Health Specialists (non-MD)	2,163
Board Certified	**Number of Plan Providers in Maryland**
Yes	21,266
No	14,178

* CareFirst has two health benefit plans (GHMSI and CFMI) in the PPO category that share a combined provider network.

Data Source: Maryland Plan BHA Submission, Maryland Health Plan QP Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

CARRIER DISPARITIES INITIATIVES

CareFirst BlueChoice/GHMSI/CFMI – Number of Providers by Specialty and County/Jurisdiction

Region	County/ Jurisdiction	Family Medicine		Internal Medicine		OB/GYN Physicians		Pediatricians		Geriatricians		Psychiatrists		Other Physician Specialists (non BH)		Behavioral Health Specialists (non MD)	
		HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO
Western Maryland	Allegany	26	25	73	77	13	11	22	24	8	8	8	69	122	124	37	42
	Garrett	12	12	3	2	0	0	0	0	0	0	0	7	16	18	3	5
	Washington	65	59	94	96	25	22	63	48	4	3	22	165	254	254	106	82
Southern Maryland	Calvert	35	29	102	105	20	27	39	32	7	7	7	76	238	227	61	46
	Charles	56	55	82	83	24	21	39	33	3	3	3	49	211	213	61	66
	St. Mary's	18	26	61	69	6	7	42	35	8	6	7	57	192	196	33	30
Eastern Shore	Caroline	21	19	4	5	0	0	1	1	0	0	0	5	14	15	1	0
	Cecil	45	44	58	68	16	17	28	28	1	2	6	117	132	141	75	49
	Dorchester	10	8	7	10	4	4	3	3	1	1	5	63	35	37	18	15
	Kent	10	10	21	20	4	5	5	5	1	1	1	17	46	52	12	7
	Queen Anne's	13	15	13	12	14	16	17	16	0	0	2	52	118	124	49	31
	Somerset	1	3	5	4	10	10	5	6	0	0	3	20	13	15	20	7
	Talbot	18	18	48	46	12	14	10	10	1	1	7	62	136	129	32	12
	Wicomico	12	13	90	86	31	32	48	46	4	3	15	128	220	217	72	31
	Worcester	24	27	52	53	5	4	3	3	1	2	0	32	145	138	23	10
National Capital	Frederick	104	115	101	111	49	45	186	180	9	10	32	234	488	464	151	107
	Montgomery	228	257	821	819	326	303	538	474	33	34	77	948	1,991	2,097	470	247
	Prince George's	115	129	547	569	143	119	208	201	23	22	32	346	1,171	1,182	233	224
Baltimore	Anne Arundel	323	377	517	534	136	150	339	300	21	9	31	435	1,229	1,248	343	232
	Baltimore	411	429	1,039	1,070	219	226	263	253	50	41	134	1,164	2,080	2,097	630	352
	Baltimore City	256	289	1,806	1,916	388	360	600	630	63	73	80	1,100	3,913	4,011	388	218
	Carroll	54	53	108	98	24	20	45	43	5	3	16	217	263	263	168	100
	Harford	154	161	203	190	40	39	112	105	3	1	17	227	477	470	200	113
	Howard	151	158	285	269	64	60	122	118	10	6	37	408	581	565	249	137
	Unknown	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Data Source: Maryland Plan BHA Submission, Maryland Health Plan QP Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

CARRIER DISPARITIES INITIATIVES

Cigna uses race, ethnicity and language data to identify members who may be encountering barriers to good health. This information is used to create interventions such as helping African American customers get life-saving cancer screenings and learn ways to manage blood pressure. Language needs have been addressed when helping Hispanic members with diabetes and heart disease improve their preventative dental care. Cigna staff are trained in cultural competency to ensure that they have the necessary skills to meet the needs of a diverse membership. In addition, health care professionals are provided ongoing access to cultural competency training and resources on a dedicated webpage.

PPO	
Provider Specialty	**Number of Plan Providers in Maryland**
Family Medicine	1,888
Internal Medicine	4,960
OB/GYN Physicians	1,662
Pediatricians	2,148
Geriatricians	132
Psychiatrists	512
Other Physician Specialists (non-Behavioral Health)	16,508
Behavioral Health Specialists (non-MD)	2,180
Board Certified	**Number of Plan Providers in Maryland**
Yes	19,962
No	7,848
N/A	2,180

Data Source: Maryland Plan BHA Submission, Maryland Health Plan QP Submission or Health Benefit Plan Records

Cigna – Number of Providers by Specialty and County/Jurisdiction									
Region	County/ Jurisdiction	Family Medicine	Internal Medicine	OB/GYN Physicians	Pediatricians	Geriatricians	Psychiatrists	Other Physician Specialists (non BH)	Behavioral Health Specialists (non MD)
		POS/PPO							
Western Maryland	Allegany	33	70	15	22	0	7	186	19
	Garrett	30	8	3	0	4	0	39	0
	Washington	90	99	35	65	1	19	342	35
Southern Maryland	Calvert	30	70	17	21	1	9	161	45
	Charles	50	87	42	46	0	3	217	30
	St. Mary's	20	35	9	20	1	7	86	25
Eastern Shore	Caroline	20	4	0	2	0	0	1	2
	Cecil	56	28	16	17	0	9	153	27
	Dorchester	11	19	0	3	0	7	39	12
	Kent	25	10	7	5	0	0	34	9
	Queen Anne's	12	19	2	4	0	3	20	26
	Somerset	5	10	2	2	0	2	33	3
	Talbot	28	55	23	21	1	5	166	17
	Wicomico	24	91	32	32	0	8	313	21
	Worcester	24	23	5	4	1	1	61	9
National Capital	Frederick	94	110	34	63	4	26	431	123
	Montgomery	290	724	384	479	11	82	2,673	270
	Prince George's	242	448	154	180	10	36	1,454	121
Baltimore	Anne Arundel	187	418	180	179	7	26	1,159	270
	Baltimore	242	939	250	292	22	133	2,390	508
	Baltimore City	174	1,314	312	471	58	48	5,480	169
	Carroll	69	77	28	49	2	13	230	135
	Harford	71	120	38	84	4	17	299	125
	Howard	61	182	74	87	5	51	541	179
	Unknown	0	0	0	0	0	0	0	0

Data Source: Maryland Plan BHA Submission, Maryland Health Plan QP Submission or Health Benefit Plan Records

COVENTRY Health Care

Coventry Health Care was purchased by Aetna in May 2013. Customers of Coventry Health Care should expect the eventual adoption of Aetna's brand name and business practices, which include Aetna's race/ethnicity and language programs. Until that time, Coventry Health Care is continuing the use of its cultural diversity indicators, with concentrations that parallel the U.S. Census Bureau assessment of the Maryland population, when considering the programs and activities involved in patient care.

HMO	
Provider Specialty	**Number of Plan Providers in Maryland**
Family Medicine	1,446
Internal Medicine	1,664
OB/GYN Physicians	1,309
Pediatricians	1,117
Geriatricians	94
Psychiatrists	271
Other Physician Specialists (non-Behavioral Health)	8,654
Behavioral Health Specialists (non-MD)	1,011
Board Certified	**Number of Plan Providers in Maryland**
Yes	10,898
No	4,668

PPO	
Provider Specialty	**Number of Plan Providers in Maryland**
Family Medicine	1,446
Internal Medicine	1,664
OB/GYN Physicians	1,309
Pediatricians	1,117
Geriatricians	94
Psychiatrists	271
Other Physician Specialists (non-Behavioral Health)	8,654
Behavioral Health Specialists (non-MD)	1,061
Board Certified	**Number of Plan Providers in Maryland**
Yes	10,898
No	4,668

Data Source: Maryland Plan BHA Submission, Maryland Health Plan QP Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

CARRIER DISPARITIES INITIATIVES

Coventry – Number of Providers by Specialty and County/Jurisdiction

Region	County/ Jurisdiction	Family Medicine		Internal Medicine		OB/GYN Physicians		Pediatricians		Geriatricians		Psychiatrists		Other Physician Specialists (non BH)		Behavioral Health Specialists (non MD)	
		HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO
Western Maryland	Allegany	7	7	9	9	6	6	10	10	1	1	0	0	28	28	8	8
	Garrett	4	4	1	1	0	0	0	0	0	0	0	0	3	3	0	0
	Washington	36	36	26	26	16	16	30	30	1	1	1	1	132	132	17	17
Southern Maryland	Calvert	13	13	36	36	12	12	6	6	3	3	1	1	99	99	15	15
	Charles	61	61	36	36	19	19	24	24	0	0	0	0	132	132	7	7
	St. Mary's	20	20	27	27	7	7	12	12	1	1	0	0	108	108	4	4
Eastern Shore	Caroline	20	20	6	6	0	0	3	3	0	0	0	0	0	0	1	1
	Cecil	29	29	7	7	8	8	10	10	1	1	6	6	84	84	53	53
	Dorchester	11	11	4	4	4	4	3	3	0	0	7	7	35	35	19	19
	Kent	8	8	5	5	3	3	2	2	0	0	3	3	35	35	9	9
	Queen Anne's	18	18	6	6	15	15	16	16	0	0	2	2	73	73	13	13
	Somerset	1	1	3	3	12	12	4	4	0	0	2	2	5	5	6	6
	Talbot	25	25	11	11	10	10	10	10	0	0	10	10	115	115	25	25
	Wicomico	8	8	28	28	33	33	20	20	0	0	17	17	149	149	51	51
	Worcester	18	18	11	11	4	4	4	4	0	0	1	1	88	88	17	17
National Capital	Frederick	92	92	15	15	35	35	127	127	7	7	15	15	159	159	42	42
	Montgomery	80	80	161	161	182	182	179	179	4	4	3	3	1,029	1,029	47	47
	Prince George's	100	100	155	155	116	116	95	95	4	4	6	6	720	720	25	25
Baltimore	Anne Arundel	218	218	200	200	151	151	148	148	9	9	9	9	611	611	84	84
	Baltimore	292	292	419	419	237	237	152	152	27	27	105	105	1,395	1,395	222	272
	Baltimore City	161	161	314	314	302	302	142	142	28	28	38	38	2,726	2,726	155	155
	Carroll	45	45	30	30	37	37	24	24	3	3	8	8	207	207	54	54
	Harford	111	111	80	80	35	35	47	47	2	2	8	8	331	331	85	85
	Howard	68	68	74	74	65	65	49	49	3	3	29	29	390	390	52	52
	Unknown	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Data Source: Maryland Plan BHA Submission, Maryland Health Plan QP Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

CARRIER DISPARITIES INITIATIVES

KAISER PERMANENTE

Kaiser Permanente is committed to continually collecting member demographic data on race, ethnicity, and language preference in an effort to improve the customization of care delivery and services. This information is used to meet members' linguistic needs and provide culturally appropriate services and resources. By linking that information with care quality and utilization data, they have been able to measure the scope of existing health disparities, improve understanding of their causes, and implement programs to reduce and eliminate them. Kaiser Permanente accomplishes this through their Diversity & Inclusions Department, as well as through language services, and health education programs.

HMO	
Provider Specialty	**Number of Plan Providers in Maryland**
Family Medicine	286
Internal Medicine	1,037
OB/GYN Physicians	670
Pediatricians	238
Geriatricians	65
Psychiatrists	443
Other Physician Specialists (non-Behavioral Health)	5,972
Behavioral Health Specialists (non-MD)	998
Board Certified	**Number of Plan Providers in Maryland**
Yes	7,596
No	2,113

PPO*	
Provider Specialty	**Number of Plan Providers in Maryland**
Family Medicine	843
Internal Medicine	2,360
OB/GYN Physicians	1,222
Pediatricians	976
Geriatricians	80
Psychiatrists	696
Other Physician Specialists (non-Behavioral Health)	12,582
Behavioral Health Specialists (non-MD)	1,852
Board Certified	**Number of Plan Providers in Maryland**
Yes	15,863
No	4,748

*KPIC is a POS product combining some services of both HMO and PPO products.

Data Source: Maryland Plan BHA Submission, Maryland Health Plan QP Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

CARRIER DISPARITIES INITIATIVES

Kaiser Permanente/KPIC – Number of Providers by Specialty and County/Jurisdiction

Region	County/ Jurisdiction	Family Medicine		Internal Medicine		OB/GYN Physicians		Pediatricians		Geriatricians		Psychiatrists		Other Physician Specialists (non BH)		Behavioral Health Specialists (non MD)	
		HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO
Western Maryland	Allegany	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Garrett	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Washington	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Southern Maryland	Calvert	10	14	11	35	3	10	8	18	2	2	1	4	35	96	17	46
	Charles	9	30	26	51	1	9	6	21	3	3	1	3	36	88	25	45
	St. Mary's	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Eastern Shore	Caroline	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Cecil	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Dorchester	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Kent	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Queen Anne's	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Somerset	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Talbot	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Wicomico	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Worcester	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
National Capital	Frederick	8	52	25	46	18	39	3	31	0	0	17	21	76	229	54	86
	Montgomery	55	149	280	487	129	260	58	205	6	6	36	70	712	1,809	214	343
	Prince George's	53	108	185	307	48	82	40	104	6	6	16	29	255	664	96	171
Baltimore	Anne Arundel	51	130	87	187	61	84	17	86	4	4	8	23	293	741	101	181
	Baltimore	58	161	229	493	87	195	45	164	7	12	123	139	923	1,887	194	335
	Baltimore City	8	70	98	520	261	413	26	222	35	44	201	352	3,275	6,289	111	287
	Carroll	5	33	12	41	0	10	4	17	0	0	6	8	56	125	40	86
	Harford	8	39	20	69	5	20	11	48	1	1	2	8	86	221	40	94
	Howard	21	57	64	124	57	100	20	60	1	2	32	39	225	433	106	178
	Unknown	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Data Source: Maryland Plan BHA Submission, Maryland Health Plan QP Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

CARRIER DISPARITIES INITIATIVES

UnitedHealthcare

Serving more than 75 million people, UnitedHealth Group has a distinct incentive to ensure their products and services are accessible to everyone. They have improved the collection of race and language data by making this data a part of a standard Health Assessment members are asked to complete. UnitedHealth Group addresses the individualized needs of members through the use of such data, and also provides culturally and linguistically appropriate health education materials and health care. They focus on prevention, health education, and treatment efforts for specific demographic groups with a prevalence of certain health conditions, and help improve health benefit plan performance across diverse populations. UnitedHealth Group aims to ensure equity in access and quality of care.

	MD-IPA HMO	Optimum Choice HMO	UnitedHealthcare HMO	MAMSI PPO	UnitedHealthcare PPO
Provider Specialty	**Number of Plan Providers in Maryland**				
Family Medicine	1,054	1,059	1,052	965	968
Internal Medicine	2,442	2,458	2,431	2,305	2,308
OB/GYN Physicians	862	867	863	797	799
Pediatricians	1,159	1,166	1,158	1,084	1,086
Geriatricians	88	81	81	80	80
Psychiatrists	156	156	156	156	156
Other Physician Specialists (non-Behavioral Health)	5,988	6,046	5,979	5,466	5,468
Behavioral Health Specialists (non-MD)	168	168	167	168	168
Board Certified	**Number of Plan Providers in Maryland**				
Yes	9,628	9,699	9,610	8,919	8,939
No	2,283	2,303	2,277	2,106	2,109

Data Source: Maryland Plan BHA Submission, Maryland Health Plan QP Submission or Health Benefit Plan Records

UnitedHealthcare – Number of Providers by Specialty and County/Jurisdiction

Region	County/ Jurisdiction	Family Medicine		Internal Medicine		OB/GYN Physicians		Pediatricians		Geriatricians		Psychiatrists		Other Physician Specialists (non BH)		Behavioral Health Specialists (non MD)	
		MD-IPA HMO	Optimum Choice HMO	MD-IPA HMO	Optimum Choice HMO	MD-IPA HMO	Optimum Choice HMO	MD-IPA HMO	Optimum Choice HMO	MD-IPA HMO	Optimum Choice HMO	MD-IPA HMO	Optimum Choice HMO	MD-IPA HMO	Optimum Choice HMO	MD-IPA HMO	Optimum Choice HMO
Western Maryland	Allegany	14	14	32	33	8	8	12	12	1	1	4	4	58	68	2	2
	Garrett	12	12	3	3	0	0	0	0	0	0	0	0	6	7	1	1
	Washington	38	38	34	36	9	9	16	16	2	2	12	12	84	84	6	6
Southern Maryland	Calvert	19	19	33	33	12	12	15	15	0	0	4	4	83	84	3	3
	Charles	48	48	69	69	25	25	40	40	1	1	1	1	185	185	2	2
	St. Mary's	20	20	33	33	8	8	17	17	2	2	3	3	67	67	2	2
Eastern Shore	Caroline	10	11	0	0	0	0	1	1	0	0	0	0	0	0	1	1
	Cecil	33	33	6	11	4	5	6	8	1	1	2	2	30	63	6	6
	Dorchester	7	7	5	5	0	0	1	1	0	0	2	2	11	11	0	0
	Kent	7	7	6	6	1	1	1	1	0	0	0	0	12	12	2	2
	Queen Anne's	16	16	5	5	0	0	2	2	7	0	1	1	7	7	1	1
	Somerset	2	2	1	1	1	1	2	2	0	0	0	0	0	0	0	0
	Talbot	8	8	13	13	8	8	12	12	0	0	0	0	56	58	2	2
	Wicomico	13	16	41	48	17	17	20	20	1	1	5	5	125	126	2	2
	Worcester	18	18	9	9	2	2	1	1	0	0	0	0	19	19	0	0
National Capital	Frederick	53	53	33	33	6	6	37	37	1	1	6	6	153	153	7	7
	Montgomery	153	153	346	346	147	147	241	241	8	8	35	35	1,088	1,090	47	47
	Prince George's	158	158	280	281	110	111	151	152	6	6	10	10	714	717	8	8
Baltimore	Anne Arundel	95	95	189	189	77	77	94	94	5	5	12	12	400	401	10	10
	Baltimore	123	123	420	420	137	137	144	145	18	18	26	26	827	828	24	24
	Baltimore City	91	91	618	618	96	98	188	190	27	27	10	10	1,338	1,339	11	11
	Carroll	33	33	45	45	13	14	24	24	1	1	5	5	90	90	8	8
	Harford	38	39	86	86	34	34	74	75	2	2	1	1	267	268	4	4
	Howard	43	43	109	109	135	135	56	56	5	5	17	17	280	280	19	19
	Unknown	2	2	26	26	12	12	4	4	0	0	0	0	88	89	0	0

Data Source: Maryland Plan BHA Submission, Maryland Health Plan QP Submission or Health Benefit Plan Records

continued

UnitedHealthcare – Number of Providers by Specialty and County/Jurisdiction continued

Region	County/ Jurisdiction	Family Medicine		Internal Medicine		OB/GYN Physicians		Pediatricians		Geriatricians		Psychiatrists		Other Physician Specialists (non BH)		Behavioral Health Specialists (non MD)	
		United-Healthcare HMO	MAMSI PPO	United-Healthcare HMO	MAMSI PPO	United-Healthcare HMO	MAMSI PPO	United-Healthcare HMO	MAMSI PPO	United-Healthcare HMO	MAMSI PPO	United-Healthcare HMO	MAMSI PPO	United-Healthcare HMO	MAMSI PPO	United-Healthcare HMO	MAMSI PPO
Western Maryland	Allegany	14	13	32	29	8	8	12	12	1	1	4	4	58	52	2	2
	Garrett	12	12	3	2	0	0	0	0	0	0	0	0	6	6	0	1
	Washington	38	36	33	34	9	9	16	16	2	2	12	12	84	81	6	6
Southern Maryland	Calvert	19	19	33	32	12	11	15	15	0	0	4	4	82	81	3	3
	Charles	48	65	69	73	25	23	40	38	1	2	1	1	185	184	2	2
	St. Mary's	20	22	33	32	8	8	17	14	2	2	3	3	67	65	2	2
Eastern Shore	Caroline	10	10	0	0	0	0	1	1	0	0	0	0	0	0	1	1
	Cecil	33	32	6	6	4	3	6	5	1	1	2	2	30	29	6	6
	Dorchester	7	7	5	5	0	0	1	1	0	0	2	2	11	11	0	0
	Kent	7	6	6	6	1	1	1	1	0	0	0	0	12	12	2	2
	Queen Anne's	16	16	5	3	2	0	1	1	0	0	1	1	8	1	1	1
	Somerset	2	1	1	1	1	0	2	2	0	0	0	0	0	0	0	0
	Talbot	8	8	13	14	8	8	12	12	0	0	0	0	56	56	2	2
	Wicomico	13	13	41	41	17	18	20	18	1	1	5	5	125	125	2	2
	Worcester	18	17	9	8	2	2	1	1	0	0	0	0	19	15	0	0
National Capital	Frederick	53	52	33	26	6	6	37	33	1	1	6	6	152	131	7	7
	Montgomery	152	133	341	294	147	115	241	211	8	8	35	35	1,081	860	47	47
	Prince George's	157	114	279	245	110	93	151	138	6	5	10	10	715	616	8	8
Baltimore	Anne Arundel	95	91	189	183	77	74	94	87	5	6	12	12	399	349	10	10
	Baltimore	123	106	418	413	136	130	144	143	18	17	26	26	827	798	24	24
	Baltimore City	91	76	618	596	96	91	189	170	27	26	10	10	1,337	1,254	11	11
	Carroll	33	32	45	45	13	13	24	22	1	1	5	5	90	86	8	8
	Harford	38	38	86	87	34	38	73	80	2	2	1	1	267	282	4	4
	Howard	43	45	107	104	135	135	56	59	5	5	17	17	280	285	19	19
	Unknown	2	1	26	26	12	11	4	4	0	0	0	0	88	87	0	0

Data Source: Maryland Plan BHA Submission, Maryland Health Plan QP Submission or Health Benefit Plan Records

continued

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

CARRIER DISPARITIES INITIATIVES

UnitedHealthcare – Number of Providers by Specialty and County/Jurisdiction continued

Region	County/ Jurisdiction	Family Medicine	Internal Medicine	OB/GYN Physicians	Pediatricians	Geriatricians	Psychiatrists	Other Physician Specialists (non BH)	Behavioral Health Specialists (non MD)
		UnitedHealthcare PPO							
Western Maryland	Allegany	13	29	8	12	1	4	58	2
	Garrett	12	2	0	0	0	0	6	1
	Washington	36	35	9	16	2	12	85	6
Southern Maryland	Calvert	18	33	11	15	0	4	80	3
	Charles	46	64	23	37	1	1	168	2
	St. Mary's	20	30	8	14	2	3	59	2
Eastern Shore	Caroline	10	0	0	1	0	0	0	1
	Cecil	32	7	5	6	1	2	30	6
	Dorchester	7	5	0	1	0	2	11	0
	Kent	7	6	1	1	0	0	12	2
	Queen Anne's	16	4	0	2	0	1	6	1
	Somerset	1	1	1	2	0	0	0	0
	Talbot	8	13	8	12	0	0	54	2
	Wicomico	13	41	17	18	1	5	123	2
	Worcester	18	9	2	1	0	0	18	0
National Capital	Frederick	53	31	6	34	1	6	142	7
	Montgomery	132	295	115	211	8	35	860	47
	Prince George's	111	231	89	135	5	10	575	8
Baltimore	Anne Arundel	94	184	76	87	5	12	363	10
	Baltimore	120	418	134	143	18	26	817	24
	Baltimore City	87	609	95	181	27	10	1,300	11
	Carroll	33	43	13	23	1	5	90	8
	Harford	38	85	33	74	2	1	264	4
	Howard	42	107	134	56	5	17	278	19
	Unknown	1	26	11	4	0	0	87	0

Data Source: Maryland Plan BHA Submission, Maryland Health Plan QP Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

CARRIER DISPARITIES INITIATIVES

Member Information Sources

DESCRIPTION

A disparities measure with a composite score that represents the percentage of meaningful member information sources and information being proactively captured by the health benefit plan, being used to identify RELICC™ data elements (including race/ethnicity, languages spoken other than English, interpreter need, and cultural characteristics of their enrolled members).

Maryland plans were recently permitted to begin gathering RELICC™ data directly from members in order to better address their health care needs. As a result, plans are in various stages with regard to RELICC™ data completeness.

For this measure, a higher percentage is better, which means that the plan is taking steps to gather RELICC™ data directly and proactively from members in order to better address their health care needs.

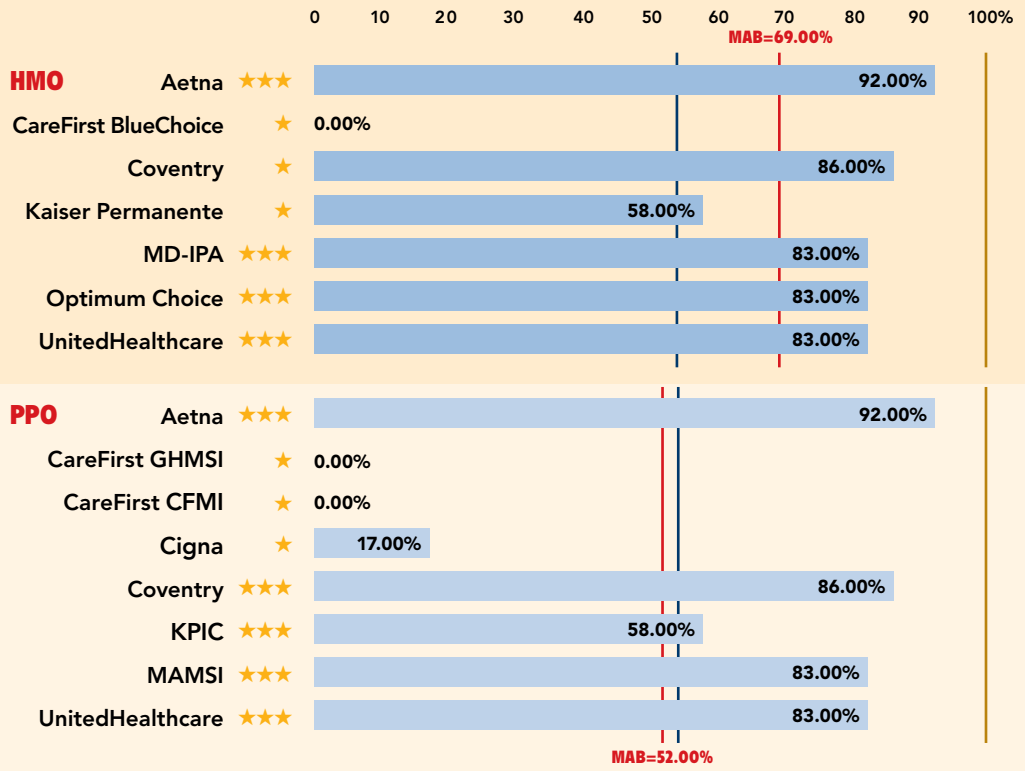
RATIONALE

According to population projections by the U.S. Census Bureau, the number of minorities living in the United States is projected to increase to about one in two by 2050. In spite of the many advances in health care, race and ethnicity remains a significant factor in determining whether an individual has adequate access to health care, receives high quality health care, and has positive health outcomes.

Proactive plans collect RELICC™ information directly from members through enrollment forms, during clinical visits, outbound disease management calls, or via surveys. Most Maryland plans rely primarily on an indirect means of acquiring the information, such as by inferring information through zip code or surname analysis. It should be noted that all plans do have at least some degree of indirect RELICC™ data and are working toward 100% directly reported RELICC™ data.

U.S. Census Bureau

IS THE PLAN GETTING ACCURATE RELICC™ MEMBER INFORMATION?



More stars indicate better health benefit plan performance.

The "stars" represent the relative comparisons between the health benefit plans and the Maryland Average Benchmark.

PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: RELICC™ Carrier Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

CARRIER DISPARITIES INITIATIVES

Information on Physicians, Physician Office Staff, and Plan Personnel

DESCRIPTION

A disparities measure with a composite score that represents the percentage of network physicians, provider office staff and health benefit plan personnel for which the plan has identified RELICC™ data elements including race/ethnicity and languages spoken other than English.

For this measure a higher percentage is better, which means that RELICC™ data elements have been identified for the provider network, provider office staff and plan personnel.

NOTE: Each RELICC™ data element is weighted differently, thus scores do not reflect a one-to-one relationship. For example, a plan with a score of 47% on this measure does not necessarily indicate the plan has 47% of the RELICC™ data on their provider network, office staff and plan personnel.

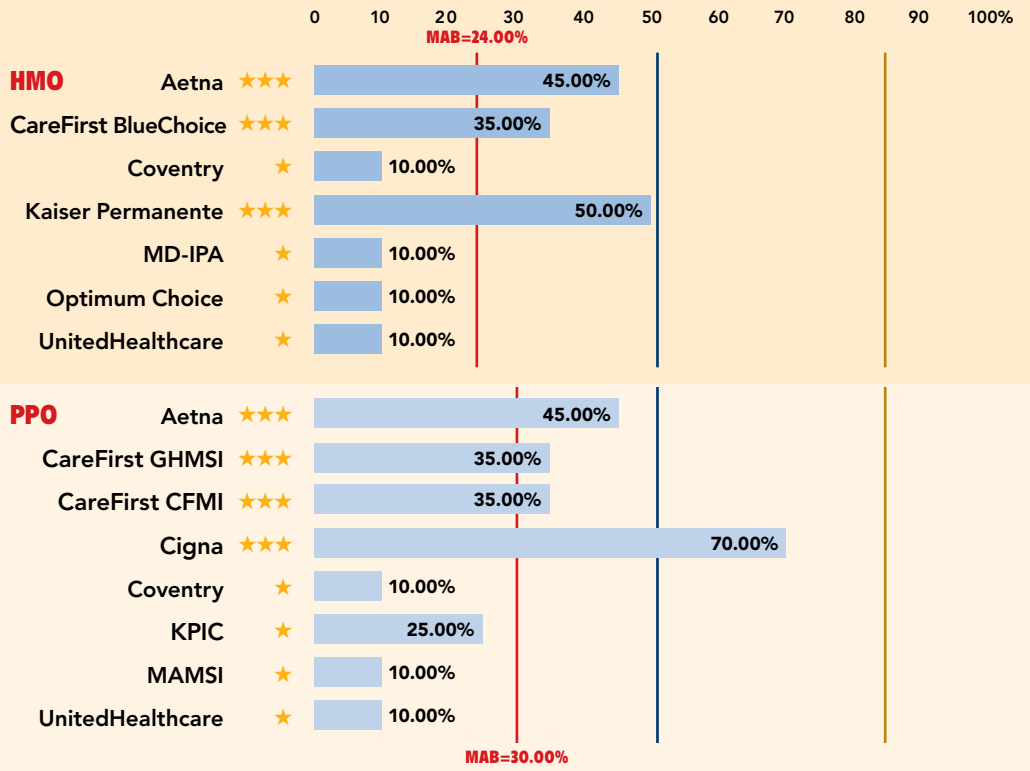
RATIONALE

"Clear communication [between patients and providers] is the foundation for patients to be able to understand and act on health information." In order to provide useful support materials and to connect patients with concordant or similar health providers if desired, health benefit plans should have information on RELICC™ characteristics, not only of their members, but also of their provider network and provider office staff.

Maryland plan performance is very inconsistent for this measure. Some plans have identified RELICC™ elements for nearly 100% of network physicians, but for none of the physicians' office staff or the plan's own internal customer service personnel. Other plans have identified RELICC™ elements for 100% of their own customer service personnel but have no information on network physicians or physician office staff and plan personnel.

Patient-Provider Communication Toolkit
Indian Health Services
U.S. Department of Health and Human Services

DOES THE PLAN KNOW THE RELICC™ INFORMATION FOR THEIR DOCTORS AND STAFF?



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PERFORMANCE RATING

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BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: RELICC™ Carrier Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

CARRIER DISPARITIES INITIATIVES

Using the Data

DESCRIPTION

A disparities measure with a composite score that represents the percentage of meaningful ways the health benefit plan uses RELICC™ data elements of their enrolled members, network providers, and their own plan customer service personnel, as well as organizational RELICC™ related programming data, to eliminate disparities.

For this measure, a higher percentage is better, which means the plan is using the RELICC™ data elements of their members, network providers and plan personnel in meaningful ways to eliminate disparities.

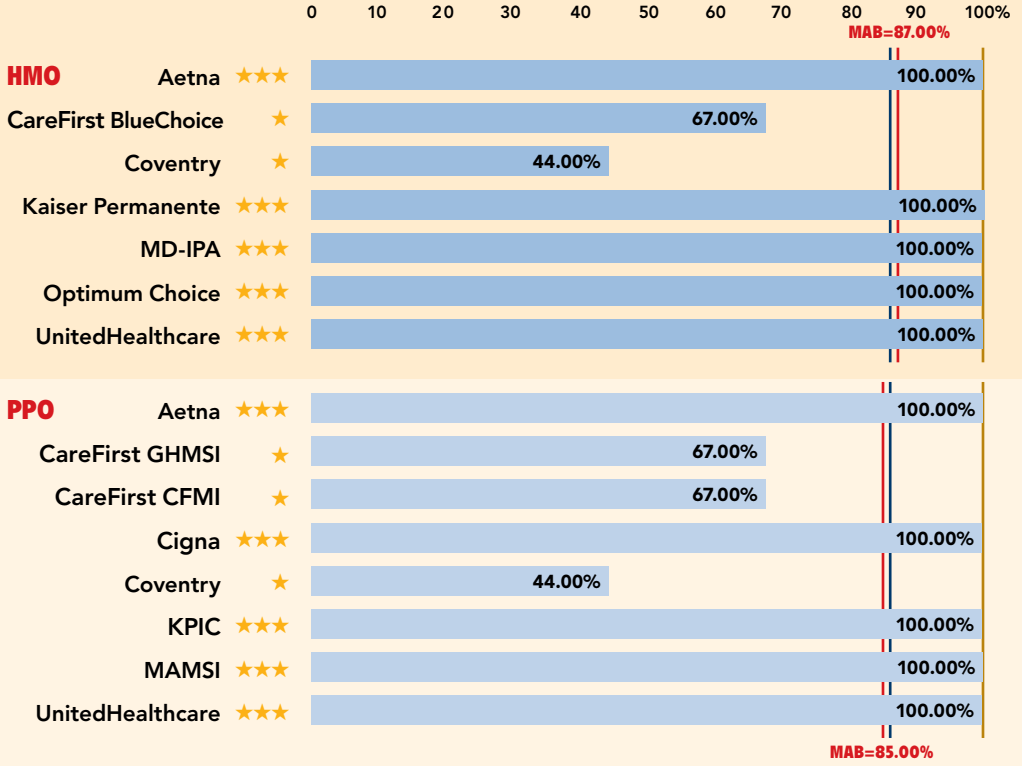
RATIONALE

The National Prevention Council advises that health benefit plans can take action to eliminate disparities by training and hiring "more qualified staff from underrepresented racial and ethnic minorities and people with disabilities."

Most Maryland plans do a good job with the limited RELICC™ data they have. Plans use the data to improve language support activities; focus quality improvement efforts; assess the adequacy of language assistance to meet members' needs; and create culturally sensitive disease management, health education and health promotion programs. Other effective ways to use data include exploring protocols for contracting with and incentivizing providers, as well as collecting and sharing members' comprehensive RELICC™ information with related providers, and helping them provide culturally competent care.

National Prevention Council
Office of the Surgeon General
U.S. Department of Health and Human Services

DOES THE PLAN USE THE DATA TOWARD ELIMINATING DISPARITIES?



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PERFORMANCE RATING

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BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: RELICC™ Carrier Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

CARRIER DISPARITIES INITIATIVES

Supporting the Needs of Members with Limited English Proficiency

DESCRIPTION

A disparities measure with a composite score that represents the percentage of meaningful ways the health benefit plan supports the language needs of members with limited English proficiency (including users of Deaf American Sign Language).

For this measure, a higher percentage is better, which means the plan is employing multiple effective language-needs strategies to assist their members whose primary language is not English.

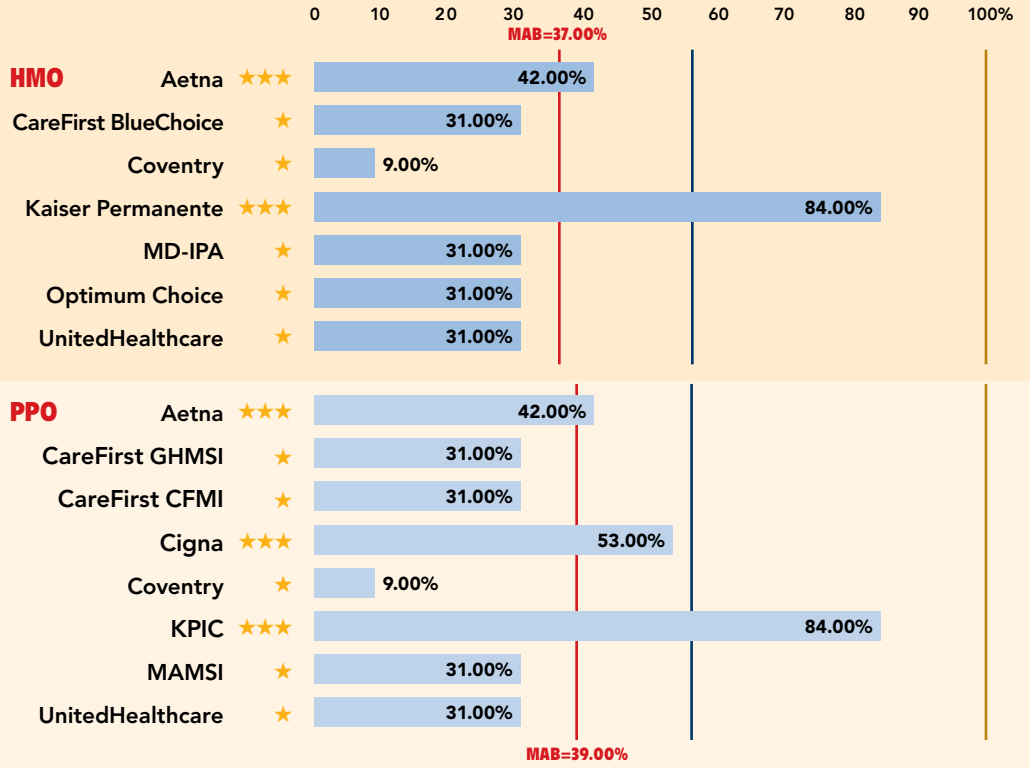
RATIONALE

Health literacy is defined as "the degree to which an individual has the capacity to obtain, communicate, process, and understand basic health information and services to make appropriate health decisions." It is crucial to identify and implement successful communication strategies for all members including those with limited English proficiency (LEP).

Maryland plans are inconsistently meeting the needs of LEP members. Many plans pay for telephonic interpreter services, and verify the proficiency of interpreters to understand and communicate medical terms. However, few plans test the foreign language proficiency of network physicians, physicians' office staff, or their own customer service plan staff. Other effective strategies include distributing translated lists of bi/multi-lingual clinicians to members, and providing or paying for in-person professional interpreter services and foreign language training for providers.

Centers for Disease Control and Prevention

HOW WELL DOES THE PLAN HELP MEMBERS WITH LANGUAGE CHALLENGES?



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BENCHMARKS

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NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: RELICC™ Carrier Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

CARRIER DISPARITIES INITIATIVES

Assuring that Culturally Competent Health Care is Delivered

DESCRIPTION

A disparities measure with a composite score that represents the percentage of meaningful ways the health benefit plan assures that culturally competent health care is delivered.

For this measure, a higher percentage is better, which means the plan is finding ways to assure that culturally competent health care is delivered.

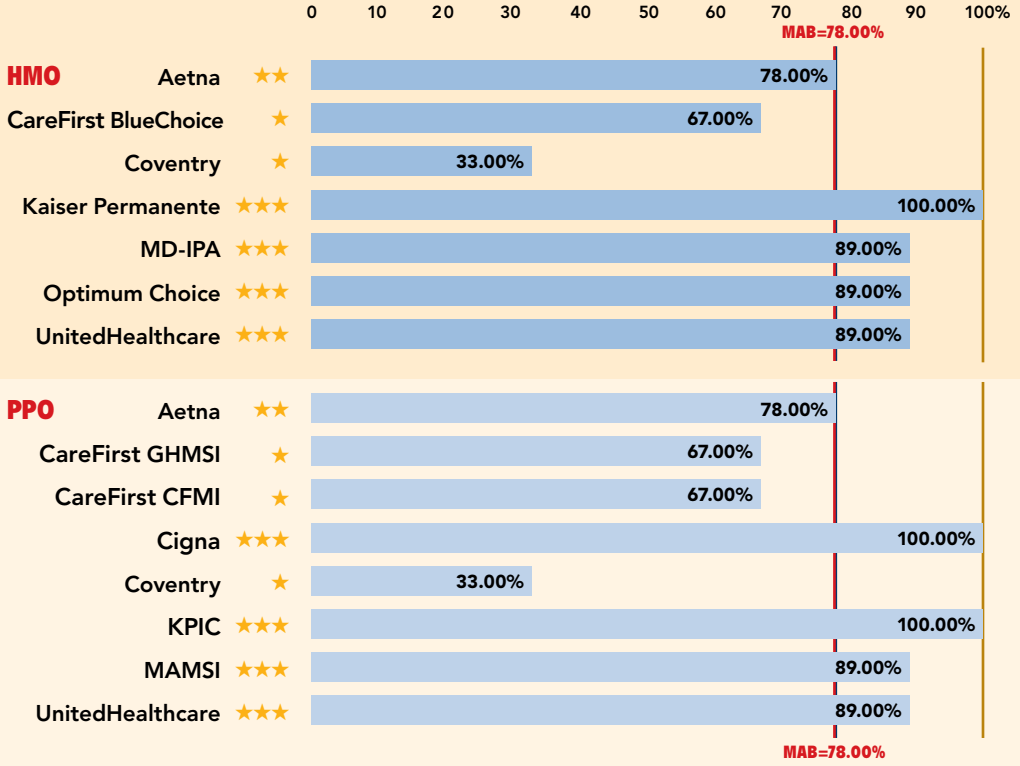
RATIONALE

"… Prevention communications should take the culture (e.g., language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious or social groups) of the target population into consideration to be effective."

Overall, Maryland plans are making good efforts to assure the delivery of culturally competent care by assessing members' needs, tailoring health promotion and disease management messaging to particular cultural groups, and involving the community by seeking advice from Community Advisory Boards and other community-based organizations, plus collaborating with medical associations focused on cultural competency issues. Additional strategies include conducting a cultural competency needs assessment of the plan itself and its network of provider offices, and sponsoring training as necessary.

National Center for Chronic Disease Prevention and Health Promotion, 2013
Centers for Disease Control and Prevention

DOES THE PLAN SUPPORT THE COMPLETE CULTURAL HEALTH NEEDS OF MEMBERS?



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BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: RELICC™ Carrier Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

CARRIER DISPARITIES INITIATIVES

Evaluating and Measuring the Impact of Language Assistance

DESCRIPTION

A disparities measure with a composite score that represents the percentage of meaningful results from the health benefit plan's evaluation and measurement of the impact of language assistance programs or initiatives aimed at better serving the needs of their enrolled members, network providers and their office staff, as well as the plan's own customer service personnel.

For this measure, a higher percentage is better, which means the plan is effectively evaluating and measuring the impact of language assistance programs and initiatives to ensure that members in need of language assistance are provided with high quality language services, using certified medical interpreters or trained staff.

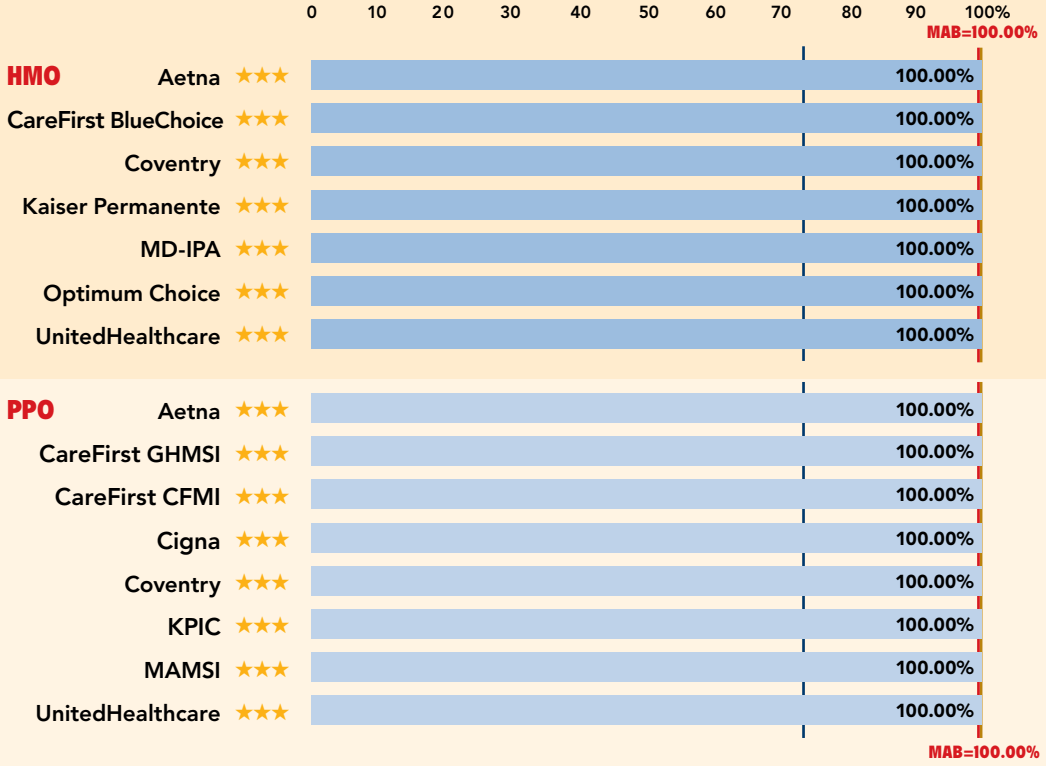
RATIONALE

Studies show that when offered a choice, minority patients are more likely to select a provider of a similar race/ethnicity, and have a higher degree of patient satisfaction. Several reasons for this include the removal of language barriers, the ability to communicate more effectively, and the assumption that similar cultural beliefs and values will be shared.

Maryland plan scores reflect their outstanding efforts to measure the impact of their language assistance programs and initiatives. All plans are actively engaged in stringently measuring the success of individual programs directed at specific populations and the effectiveness of language support in call center operations.

Health Services Research, 2010 National Center for Biotechnology Information U.S. National Library of Medicine National Institutes of Health

HOW WELL DOES THE PLAN CRITIQUE THEIR OWN LANGUAGE ASSISTANCE EFFORTS?



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BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: RELICC™ Carrier Submission or Health Benefit Plan Records

Information Available through the Online Provider Directory

DESCRIPTION

A disparities measure with a composite score that represents the percentage of meaningful ways RELICC™ information on the health benefit plan's provider network is made available to members through the online provider directory.

For this measure, a higher percentage is better, which means the plan is effectively using their online provider directory in order to share providers' RELICC™-related characteristics which are important to their members.

RATIONALE

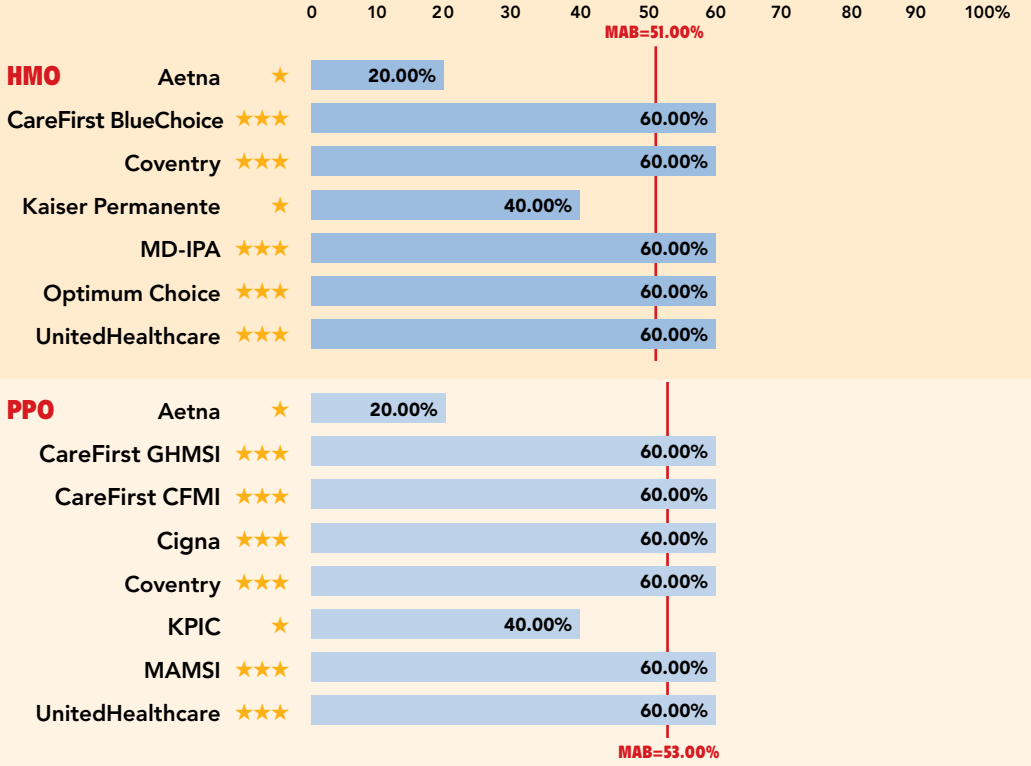
To make informed provider selections, plan members should have access to relevant information on the provider network. Also, to process and pay claims correctly, plans need to maintain accurate information on network providers.

"Member Services are also part of a provider network [thus directories include]… both entity information and individual provider information."

While most Maryland plans offer searchable information on provider location, phone, specialty, gender, and languages spoken, few plans offer searchable information on office hours or years in practice. In addition to the basic information noted above, dynamic provider directories also include degree and residency information, licensing information, hospital and group affiliations, and whether providers are accepting new patients. Additionally, this information should also be rankable according to member preferences, and allow for side-by-side provider comparison.

Office of the National Coordinator for Health Information Technology U.S. Department of Health and Human Services

CAN MEMBERS PRIORITIZE SEARCH CRITERIA TO FIND DOCTORS IN THE ONLINE DIRECTORY?



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★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE) – National benchmark not available
NTP (NATIONAL TOP PERFORMERS) – National Benchmark not available

Data Source: RELICC™ Carrier Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

CARRIER DISPARITIES INITIATIVES

Interactive Selection Features for Members Selecting a Physician Online

DESCRIPTION

A disparities measure with a composite score that represents the percentage of meaningful ways members can interact with the health benefit plan's online physician selection tool to select provider features that are of importance to them as members.

For this measure, a higher percentage is better, which means the plan is effectively maintaining a highly interactive online provider directory in order to share providers' professional features and other RELICC™-related characteristics which are important to their members.

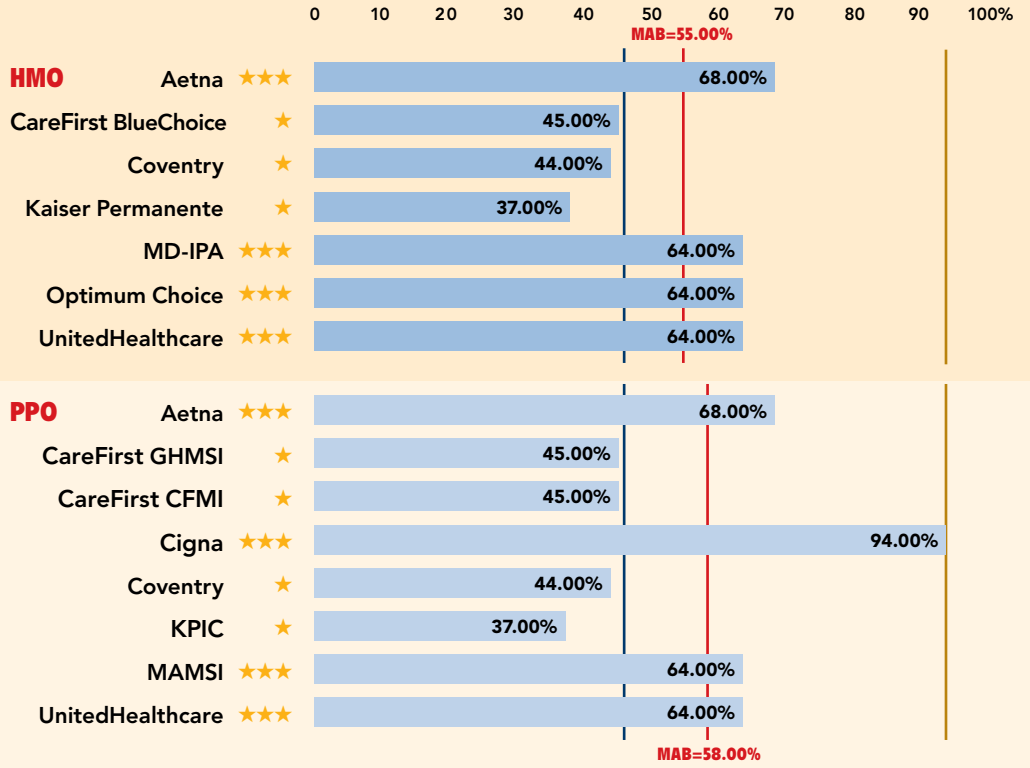
RATIONALE

Health benefit plan members often rely on technology to help them find culturally concordant or similar health care providers. Provider directories can be important sources for this information. Some directories are more sophisticated than others and are structured to allow convenient searches according to a member's preference for one or more provider categories such as gender, location, etc. Better directories guide members to the right doctor for them.

Some Maryland plans provide fairly strong interactive physician selection features within their provider directories. Almost all support members in searching for providers by treatment or condition and by culture. Most plans need to add the ability to rank or filter physician lists by member preferences, and provide members with guidance about provider choice, as well as questions to ask providers or the plan. Few plans provide a photo for at least 50% of their physicians.

Office of the National Coordinator for Health Information Technology U.S. Department of Health and Human Services

DOES THE PLAN WEBSITE HELP MEMBERS WITH THE RIGHT GUIDANCE?



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PERFORMANCE RATING

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BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: RELICC™ Carrier Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

CARRIER DISPARITIES INITIATIVES

Health Assessment Programming

DESCRIPTION

A disparities measure with a composite score that represents the percentage of meaningful ways the health benefit plan engages their members in Health Assessment completion and subsequent activities that reduce their members' health risk.

For this measure, a higher percentage is better, which means the plan is effectively reaching out to their members to facilitate completion of the plan's Health Assessment (HA), and that the HA content is comprehensive.

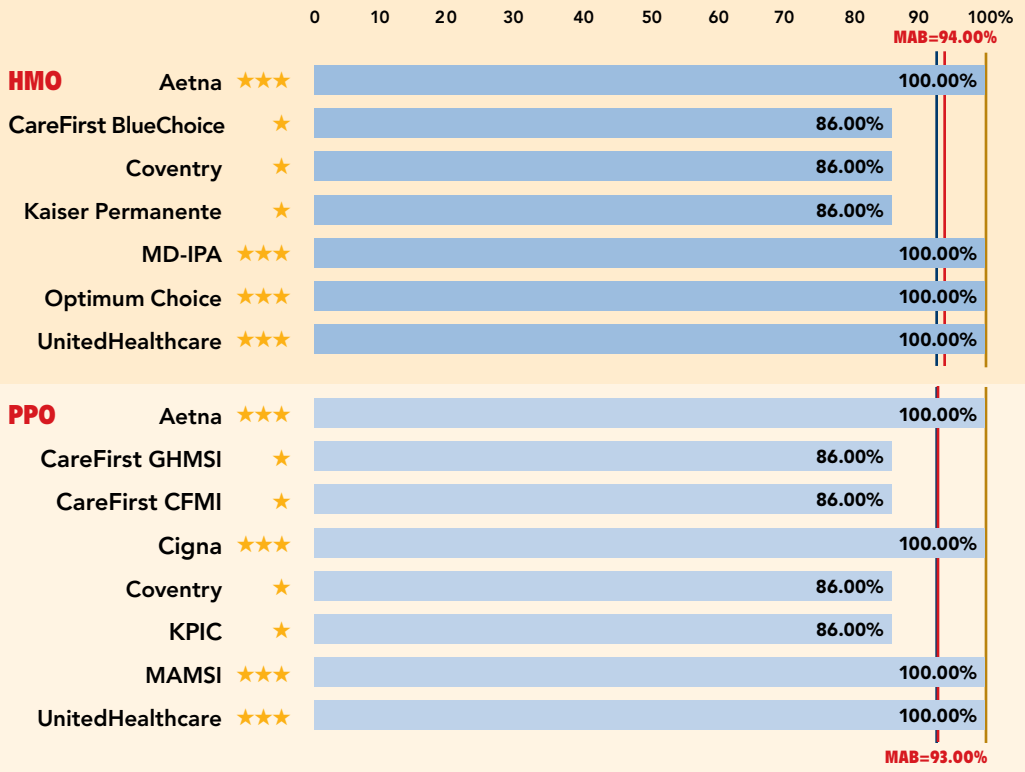
RATIONALE

Health Assessments (HAs), sometimes known as Health Risk Appraisals, help members understand their current health status and what their unique health risks might be, as well as guide members to resources that can improve their health. RELICC™- related issues play a strong role in making HAs user-friendly and helping members understand their unique health profile.

All Maryland plans have personal HAs available to members, providing the tool online and in print, and in multiple language options. Most plans provide member-specific behavior change recommendations that reduce risk. All plans need to provide access to the HAs through an Interactive Voice Recognition system or telephone interview with a live person.

Healthier Worksite Initiative (2010) Centers for Disease Control and Prevention

DOES THE PLAN HELP MEMBERS ADDRESS THEIR HEALTH RISKS?



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BENCHMARKS

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NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: RELICC™ Carrier Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care and Wellness for Children and Adolescents

Effective primary care and wellness practices assist with the prevention or early detection of childhood conditions that may prove detrimental to healthy development. These same wellness practices can assist to develop a health-centered child who in turn is likely to develop into a healthy adult and potentially minimize overall health costs throughout life.

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

PRIMARY CARE AND WELLNESS FOR CHILDREN AND ADOLESCENTS

Children and Adolescents Access to Primary Care Providers

DESCRIPTION

Each health benefit plan reports on multiple indicators under this measure. Four separate indicators include:

1. The percentage of children aged 12 to 24 months in 2013 who had a visit with a primary care provider during the 2013 measurement year.

For this performance indicator, a higher percentage is better, which means that more toddlers did have a visit to a primary care provider.

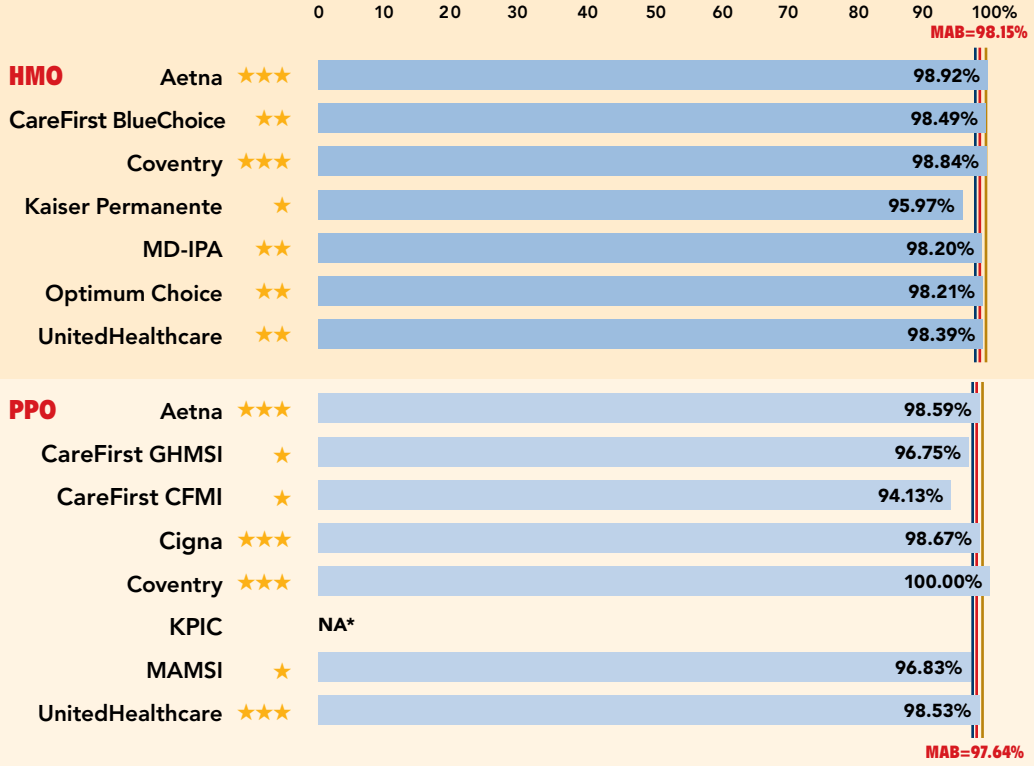
RATIONALE

Access to primary care providers such as pediatricians, family doctors, nurse practitioners, and other providers improves opportunities for appropriate use of prevention and wellness services and the proper screening for communicable diseases. Access to health services encompasses four areas of importance:

- Coverage – lack of adequate health insurance coverage makes it difficult for people to get the health care they need
- Services – in addition to primary care and preventive services, access to emergency medical services is a crucial link in the chain of care
- Timeliness – the ability to access care quickly after a need is recognized is associated with improved patient satisfaction and health outcomes
- Workforce – to improve the nation's health, it is important to increase the number of practicing primary care providers across all communities

Healthy People 2020
U.S. Department of Health and Human Services

PRIMARY CARE VISIT 12 TO 24 MONTHS OF AGE



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BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

NA* Insufficient eligible members (fewer than 30) to calculate rate

Data Source: HEDIS® Submission or Health Benefit Plan Records

Children and Adolescents Access to Primary Care Providers continued

DESCRIPTION

2. The percentage of children aged 25 months to 6 years in 2013 who had a visit with a primary care provider during the 2013 measurement year.

For this performance indicator, a higher percentage is better, which means that more young children did have a visit to a primary care provider.

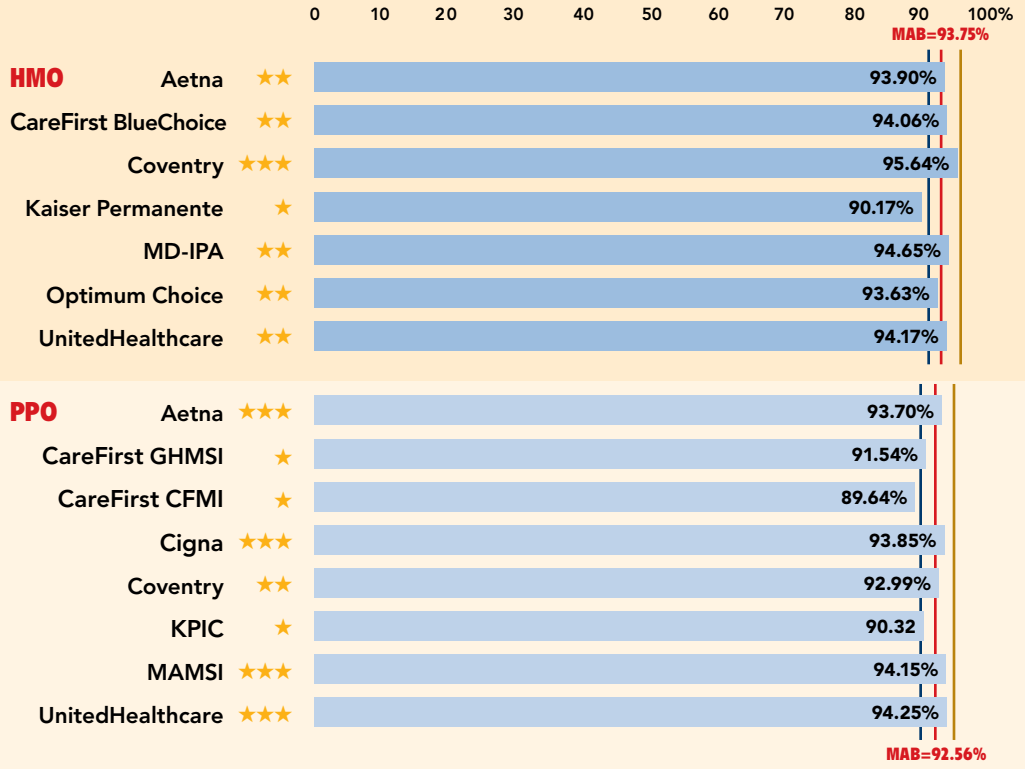
RATIONALE

Access to primary care providers such as pediatricians, family doctors, nurse practitioners, and other providers improves opportunities for appropriate use of prevention and wellness services and the proper screening for communicable diseases. Access to health services encompasses four areas of importance:

- Coverage – lack of adequate health insurance coverage makes it difficult for people to get the health care they need
- Services – in addition to primary care and preventive services, access to emergency medical services is a crucial link in the chain of care
- Timeliness – the ability to access care quickly after a need is recognized is associated with improved patient satisfaction and health outcomes
- Workforce – to improve the nation's health, it is important to increase the number of practicing primary care providers across all communities

Healthy People 2020
U.S. Department of Health and Human Services

1 PRIMARY CARE VISIT – 25 MONTHS TO 6 YEARS OF AGE



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PERFORMANCE RATING

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BENCHMARKS

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NTP (NATIONAL TOP PERFORMERS)

Data Source: HEDIS® Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

PRIMARY CARE AND WELLNESS FOR CHILDREN AND ADOLESCENTS

Children and Adolescents Access to Primary Care Providers continued

DESCRIPTION

3. The percentage of children aged 7 to 11 years in 2013 who had a visit with a primary care provider during the 2013 measurement year or the year prior.

For this performance indicator, a higher percentage is better, which means that more older children did have a visit to a primary care provider.

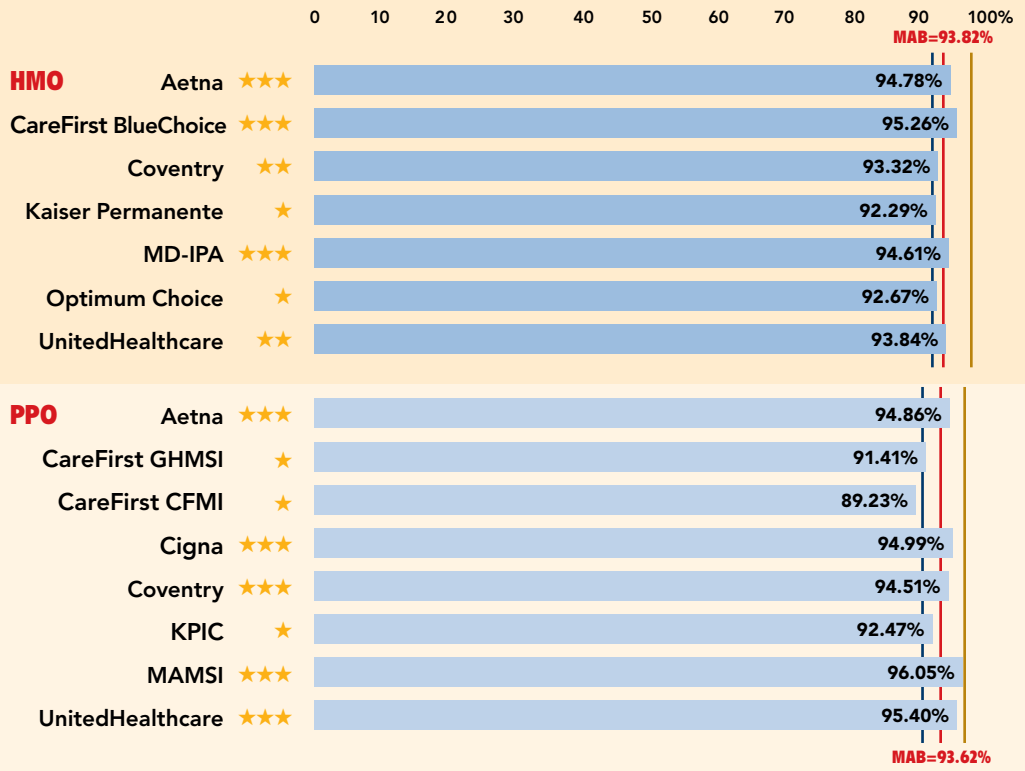
RATIONALE

Access to primary care providers such as pediatricians, family doctors, nurse practitioners, and other providers improves opportunities for appropriate use of prevention and wellness services and the proper screening for communicable diseases. Access to health services encompasses four areas of importance:

- Coverage – lack of adequate health insurance coverage makes it difficult for people to get the health care they need
- Services – in addition to primary care and preventive services, access to emergency medical services is a crucial link in the chain of care
- Timeliness – the ability to access care quickly after a need is recognized is associated with improved patient satisfaction and health outcomes
- Workforce – to improve the nation's health, it is important to increase the number of practicing primary care providers across all communities

Healthy People 2020
U.S. Department of Health and Human Services

1 PRIMARY CARE VISIT – 7 TO 11 YEARS OF AGE



More stars indicate better health benefit plan performance.

The "stars" represent the relative comparisons between the health benefit plans and the Maryland Average Benchmark.

PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: HEDIS® Submission or Health Benefit Plan Records

Children and Adolescents Access to Primary Care Providers continued

DESCRIPTION

4. The percentage of children aged 12 to 19 years in 2013 who had a visit with a primary care provider during the 2013 measurement year or the year prior.

For this performance indicator, a higher percentage is better, which means that more adolescents did have a visit to a primary care provider.

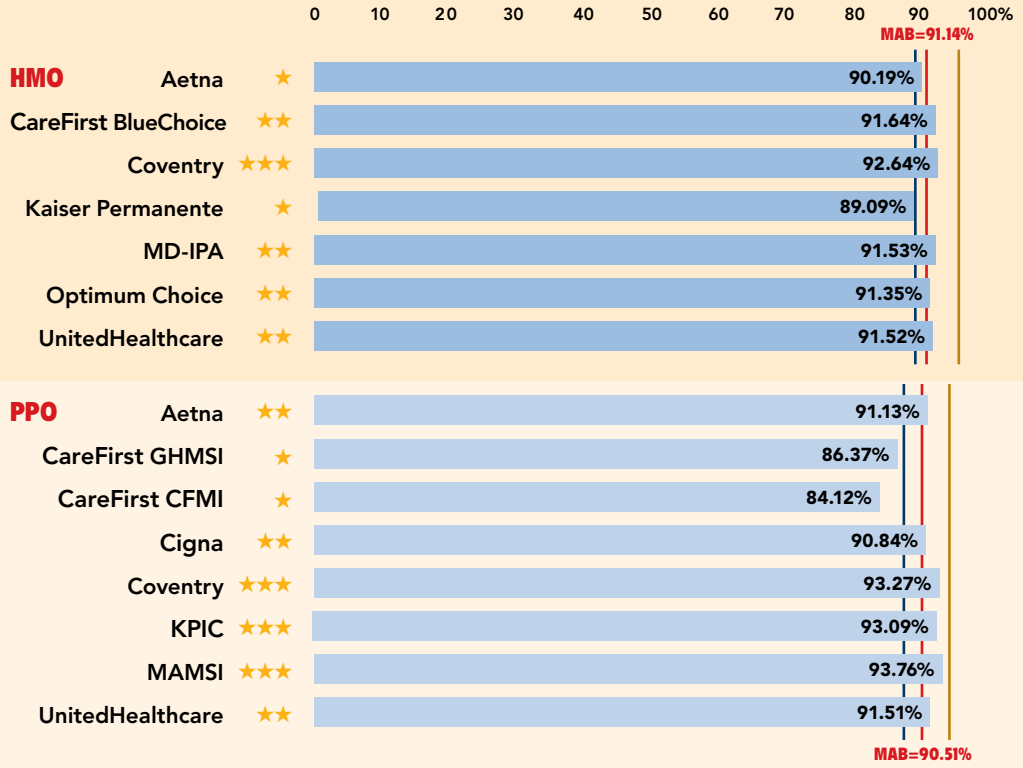
RATIONALE

Access to primary care providers such as pediatricians, family doctors, nurse practitioners, and other providers improves opportunities for appropriate use of prevention and wellness services and the proper screening for communicable diseases. Access to health services encompasses four areas of importance:

- Coverage – lack of adequate health insurance coverage makes it difficult for people to get the health care they need
- Services – in addition to primary care and preventive services, access to emergency medical services is a crucial link in the chain of care
- Timeliness – the ability to access care quickly after a need is recognized is associated with improved patient satisfaction and health outcomes
- Workforce – to improve the nation's health, it is important to increase the number of practicing primary care providers across all communities

Healthy People 2020
U.S. Department of Health and Human Services

1 PRIMARY CARE VISIT – 12 TO 19 YEARS OF AGE



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PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
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★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: HEDIS® Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

PRIMARY CARE AND WELLNESS FOR CHILDREN AND ADOLESCENTS

Well-Child Visits in the First 15 Months of Life

DESCRIPTION

Each health benefit plan reports on multiple indicators under this measure. Seven separate indicators include:

1. The percentage of children who turned 15 months of age during 2013 who had no well-child visits with a primary care provider during their first 15 months of life.

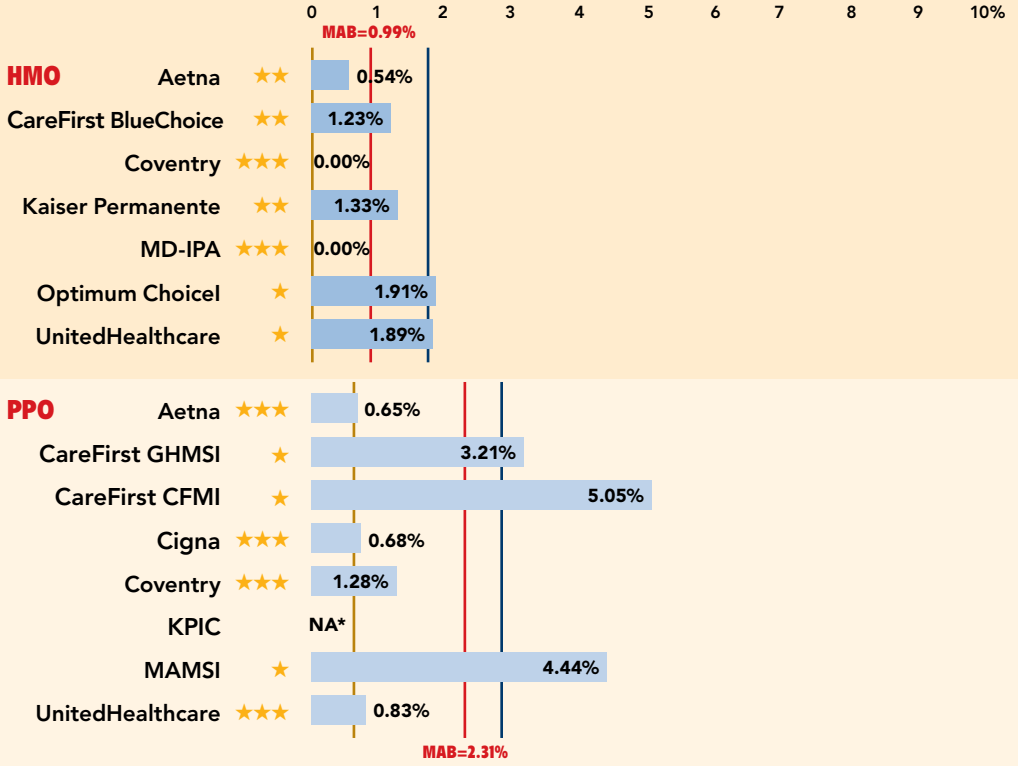
For this performance indicator, a lower percentage is better, which means that more infants and toddlers did have at least one well-child visit with a primary care provider, which is desirable, and fewer infants and toddlers had zero visits.

RATIONALE

Regular well-child checkups are one of the best ways to monitor growth and development in order to find and prevent health problems. They also provide an opportunity for the health care provider to offer guidance and counseling to the parents. These visits are of particular importance during early childhood, when infants and toddlers undergo rapid growth and change. Well-child visits are important even for healthy children because of the focus on wellness and preventive health care measures that keep children healthy.

U.S. National Library of Medicine, 2013
National Institutes of Health

0 WELL-CHILD VISITS – 0 TO 15 MONTHS OF AGE



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PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

NA* Insufficient eligible members (fewer than 30) to calculate rate

NOTE: For this performance indicator, a lower percentage is better

Data Source: HEDIS® Submission or Health Benefit Plan Records

Well-Child Visits in the First 15 Months of Life

continued

DESCRIPTION

2. The percentage of children who turned 15 months of age during 2013 who had six or more well-child visits with a primary care provider during their first 15 months of life.

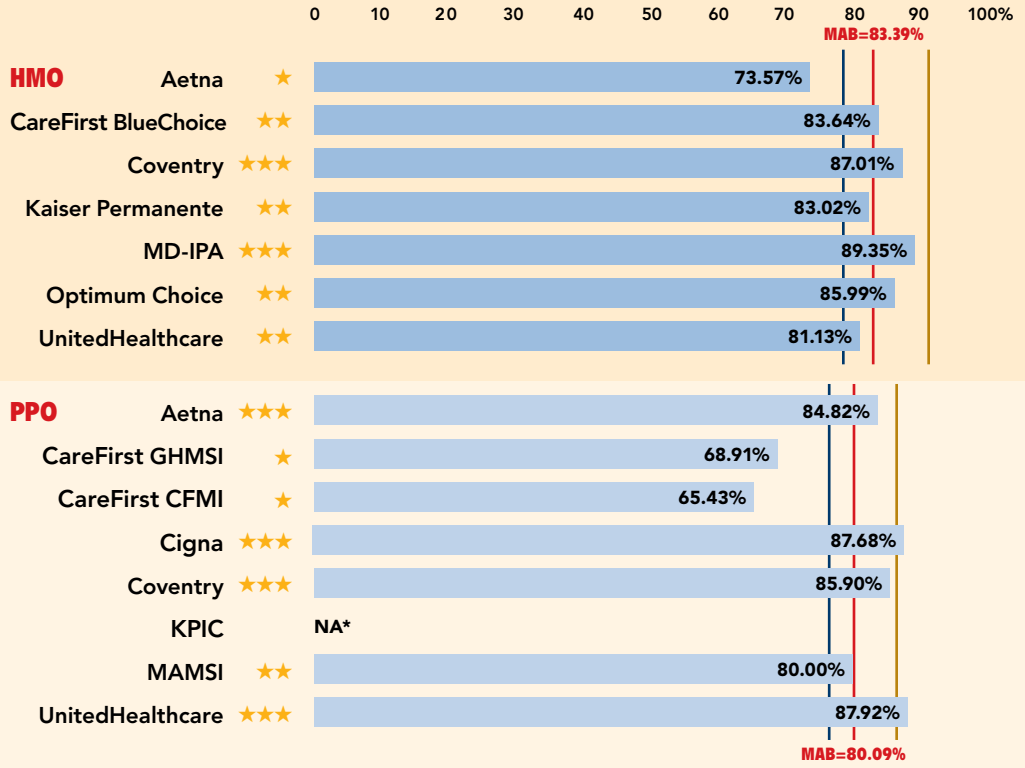
For this performance indicator, a higher percentage is better, which means that more infants and toddlers did have six or more well-child visits with a primary care provider, which is desirable, and fewer infants and toddlers had only five visits or less.

RATIONALE

Regular well-child checkups are one of the best ways to monitor growth and development in order to find and prevent health problems. They also provide an opportunity for the health care provider to offer guidance and counseling to the parents. These visits are of particular importance during early childhood, when infants and toddlers undergo rapid growth and change. Well-child visits are important even for healthy children because of the focus on wellness and preventive health care measures that keep children healthy.

U.S. National Library of Medicine, 2013
National Institutes of Health

6+ WELL-CHILD VISITS – 0 TO 15 MONTHS OF AGE



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PERFORMANCE RATING

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BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

NA* Insufficient eligible members (fewer than 30) to calculate rate

Data Source: HEDIS® Submission or Health Benefit Plan Records

Well-Child Visits in the First 15 Months of Life continued

DESCRIPTION

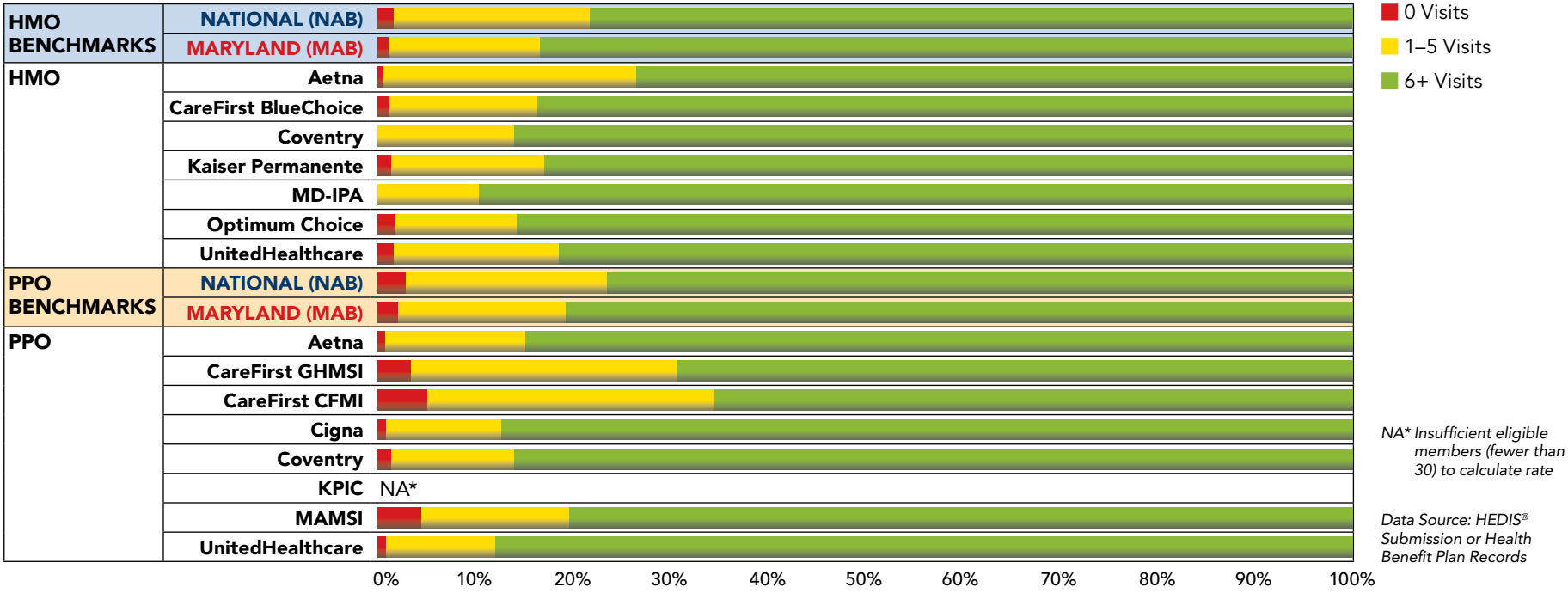
3. The percentage of children who turned 15 months of age during 2013 who had zero, one to five, or six or more well-child visit(s) with a primary care provider during their first 15 months of life.

NOTE: When evaluating health benefit plan performance, the graph below should be considered in conjunction with the prior graphs for zero visits and six or more visits. The graph below provides a summary of what the health benefit plans achieved in providing the following:

0 Visits	Undesirable; performance is displayed in red
1–5 Visits	Not necessarily good or bad; no judgment is made as to the overall performance score, no star rating is assigned and performance is displayed in yellow
6+ Visits	Desirable goal for this measure; performance is displayed in green

RATIONALE

The schedule for well-child care should be individualized based on the patient's age, health status, including health risks, previously received services, and the desired outcome of care as determined jointly by the health care practitioner and family. The goal for an adequate schedule includes at least six well child visits before the child reaches 15 months of age. However, conflicting demands on the parent(s) results in mixed ability of health benefit plans to achieve the goal of six or more visits.



NA Insufficient eligible members (fewer than 30) to calculate rate*

Data Source: HEDIS® Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

PRIMARY CARE AND WELLNESS FOR CHILDREN AND ADOLESCENTS

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

DESCRIPTION

The percentage of children aged 3 to 6 years in 2013 who received one or more well-child visits with a primary care provider during the 2013 measurement year.

For this measure, a higher percentage is better, which means that more young children did have one or more well-child visits to a primary care provider, which is desirable, and fewer young children had zero visits.

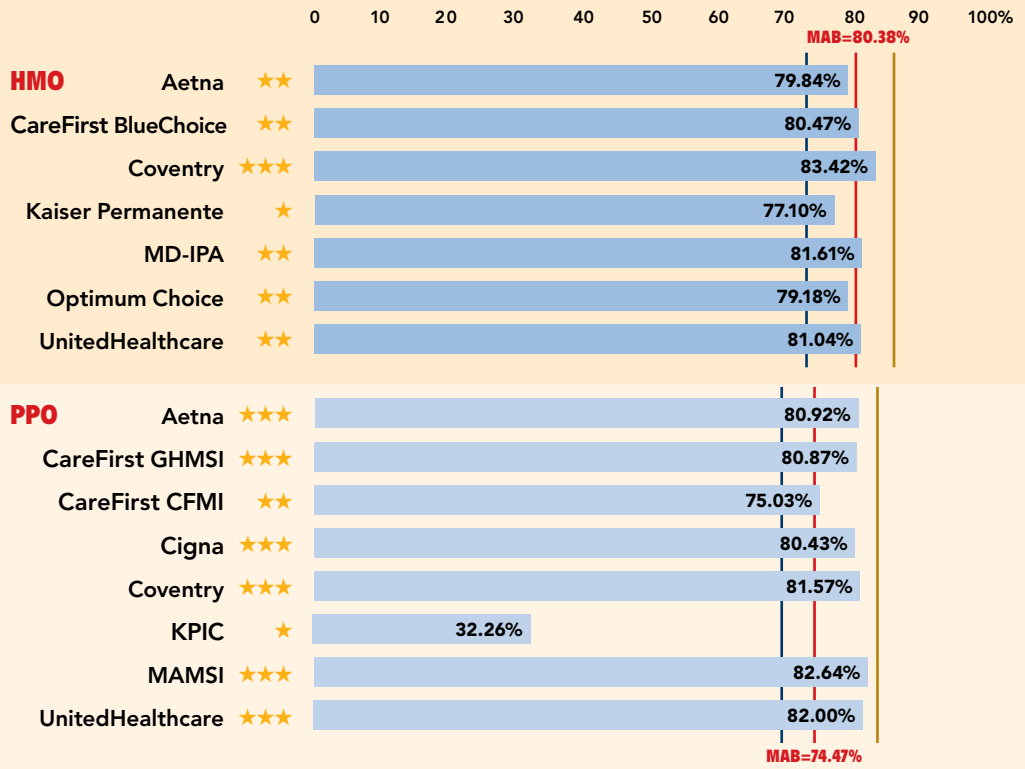
RATIONALE

Well-child visits are more than just a time for kids to get their immunizations. It is also a great time for parents to get valuable information that optimizes the health of their child. Parents should expect to get answers to questions or concerns about "normal development, nutrition, sleep, safety, diseases that are 'going around,' and other important topics."

One important topic involves vision, speech and language problems. Early intervention here can improve communication skills and avoid or reduce language and learning problems.

U.S. National Library of Medicine, 2013
National Institutes of Health

1+ WELL-CHILD VISITS – 3 TO 6 YEARS OF AGE



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PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: HEDIS® Submission or Health Benefit Plan Records

Childhood Immunization Status

DESCRIPTION

The percentage of children who turned 2 years of age during 2013 who had all the required ten immunizations by their second birthday.

The measure calculates a rate for those children who had all the required doses for immunization against several communicable diseases, including four DTaP, three IPV, one MMR, three HIB, three HepB, one VZV, four PCV, one HepA, two or three RV, and two Influenza vaccines by their second birthday. (See page 180 for more information)

For this measure, a higher percentage is better, which means that more infants and toddlers did get all their required immunizations.

NOTE: There are nineteen separate indicators in this measure category, including individual and combination immunizations. Only the total percentage of members with documented immunizations for Combo 10, which includes all the immunizations that are required for children by age 2, is represented in the associated graph.

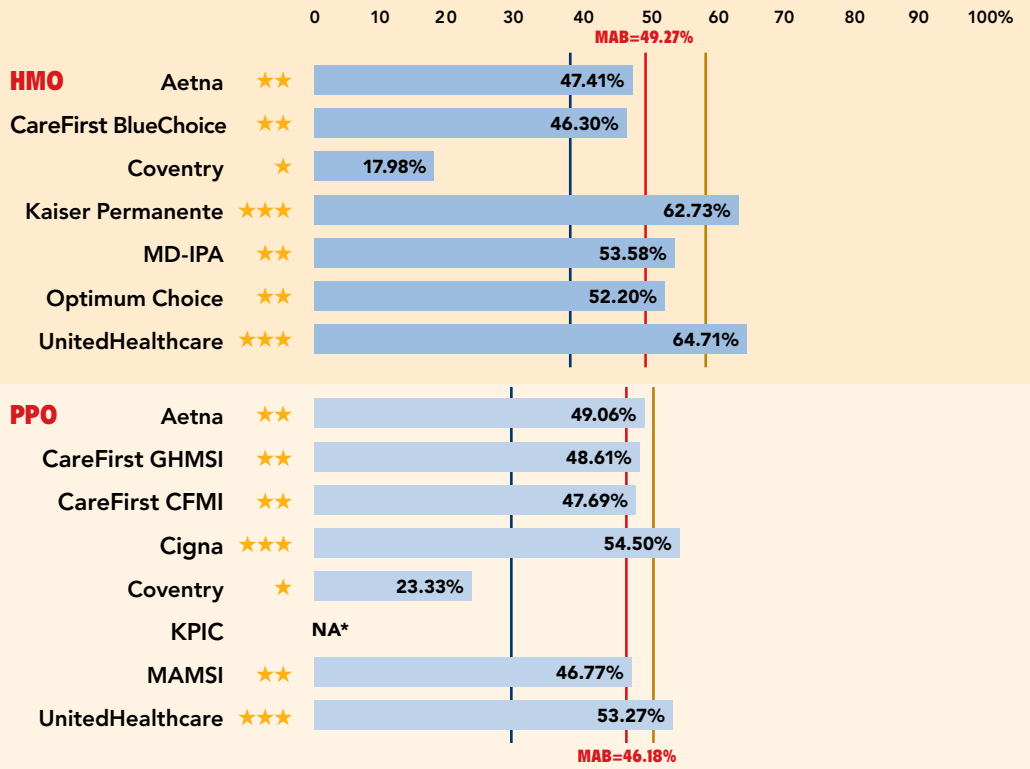
RATIONALE

One of the best ways to protect children is to make sure they have all their vaccinations. Five important reasons to vaccinate your child include:

- Immunizations can save your child's life
- Vaccination is safe and effective
- Immunization protects others you care about
- Immunizations can save your family time and money
- Immunization protects future generations

U.S. Department of Health and Human Services

10 REQUIRED IMMUNIZATIONS – 2 YEARS OF AGE



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PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
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BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

NA* Insufficient eligible members (fewer than 30) to calculate rate

Data Source: HEDIS® Submission or Health Benefit Plan Records

Adolescent Well-Care Visits

DESCRIPTION

The percentage of adolescents and young adults aged 12 to 21 years in 2013 who had at least one comprehensive well-care visit with a primary care provider or an obstetrician/gynecologist (OB/GYN) during the 2013 measurement year.

For this measure, a higher percentage is better, which means that more adolescents and young adults did have one or more well-care visits to a primary care provider or an OB/GYN.

RATIONALE

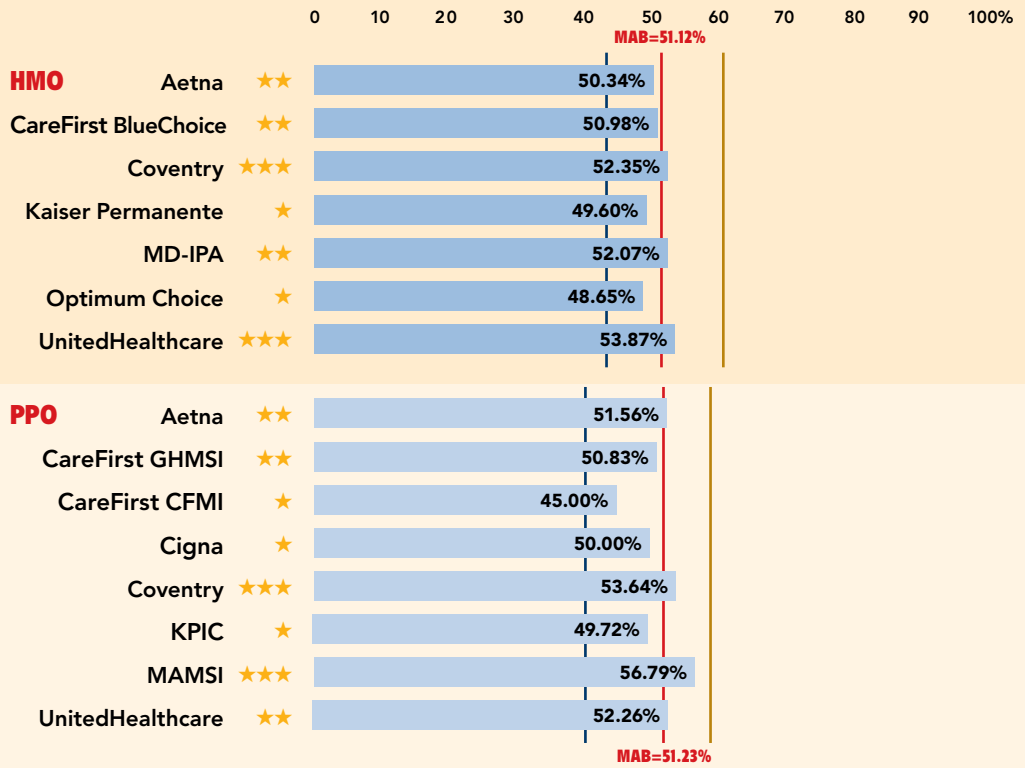
Well-care visits are more than just a time for adolescents and young adults to get their immunizations. It is also a good opportunity to get valuable information that optimizes their health. Topics that can be covered during well-care visits include questions and concerns about "normal development, nutrition, sleep, safety, diseases that are 'going around,' and other important topics."

One important topic involves emotional and social aspects of health. Not only are accidents, homicides and suicides among the leading causes of adolescent and young adult deaths, but sexually transmitted diseases, substance abuse, pregnancies, and antisocial behaviors are also important causes of, or result from, physical, emotional, and social adolescent problems.

U.S. National Library of Medicine, 2013
National Institutes of Health

National Vital Statistics Reports, 2012
Centers for Disease Control and Prevention

1+ WELL-CARE VISITS – 12 TO 21 YEARS OF AGE



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PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
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BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: HEDIS® Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

PRIMARY CARE AND WELLNESS FOR CHILDREN AND ADOLESCENTS

Immunizations for Adolescents

DESCRIPTION

The percentage of adolescents who turned 13 years of age during 2013 who had the two required immunizations for adolescents by their thirteenth birthday. The measure calculates a rate for those adolescents who had one dose of meningococcal conjugate vaccine (MCV) and one dose of tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one dose of tetanus, diphtheria toxoids vaccine (Td) by their thirteenth birthday. (See page 180 for more information)

For this measure, a higher percentage is better, which means that more adolescents who turned 13 years of age during the measurement year got all their required immunizations.

NOTE: There are three separate indicators in this measure category, including MCV, Tdap or Td, and a total of both MCV and Tdap or Td immunizations. Only the total percentage of members with documented immunizations for Combo 1, which includes all the immunizations that are required for adolescents by age 13, is represented in the associated graph.

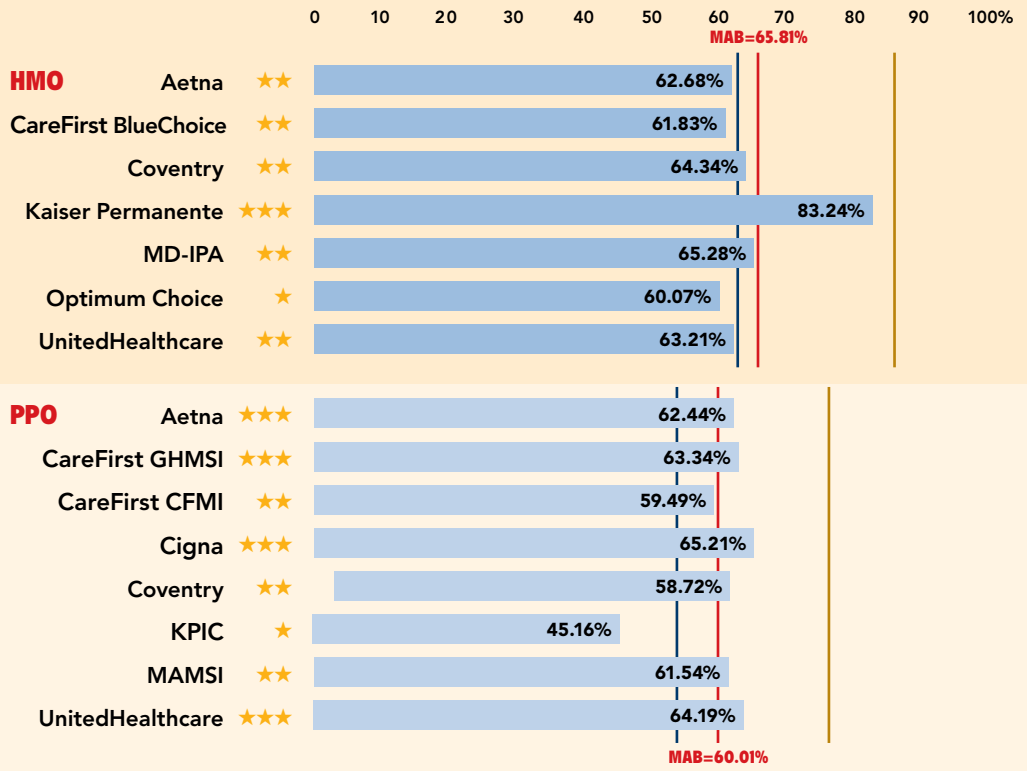
RATIONALE

One of the best ways to protect children is to make sure they have all their vaccinations. Five important reasons to vaccinate your child include:

- Immunizations can save your child's life
- Vaccination is safe and effective
- Immunization protects others you care about
- Immunizations can save your family time and money
- Immunization protects future generations

U.S. Department of Health and Human Services

2 REQUIRED IMMUNIZATIONS – 13 YEARS OF AGE



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PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: HEDIS® Submission or Health Benefit Plan Records

Human Papillomavirus Vaccine for Female Adolescents

DESCRIPTION

The percentage of female adolescents who turned 13 years of age during 2013 who had three doses of the human papillomavirus (HPV) vaccine by their thirteenth birthday.

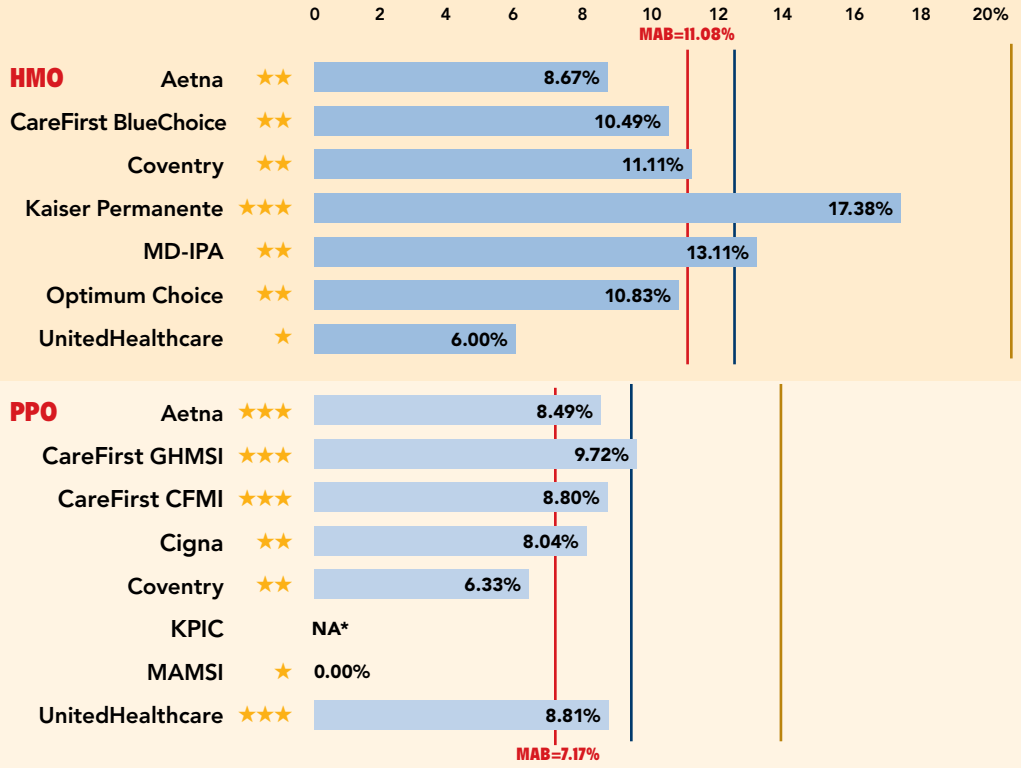
For this measure, a higher percentage is better, which means that more parents/guardians for female adolescents who turned 13 years of age during the measurement year not only authorized the optional HPV vaccination, but also followed through with attending two additional visits in order to complete the three-shot vaccination series.

RATIONALE

Genital human papillomavirus (HPV) is the most common sexually transmitted infection in the United States. According to the Centers for Disease Control and Prevention, approximately 79 million Americans are currently infected with HPV. In fact, it is so common that "most sexually-active men and women will get at least one type of HPV at some point in their lives." Genital warts and cervical cancer are two common health problems related to HPV. The HPV vaccine can offer protection against contracting the viral infection, which could reduce the need for medical care, biopsies and invasive procedures associated with follow-up from abnormal Pap tests and thereby reduce health care costs.

Centers for Disease Control and Prevention, 2013

RECOMMENDED HPV IMMUNIZATION – 13 YEARS OF AGE



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PERFORMANCE RATING

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BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

NA* Insufficient eligible members (fewer than 30) to calculate rate

Data Source: HEDIS® Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

PRIMARY CARE AND WELLNESS FOR CHILDREN AND ADOLESCENTS

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents

DESCRIPTION

Each health benefit plan reports on multiple indicators under this measure. Three separate indicators include:

1. The percentage of children and adolescents aged 3 to 17 years in 2013 who had an outpatient visit with a primary care provider or obstetrician/gynecologist (OB/GYN) and whose weight and body mass index (BMI) was assessed and documented in the 2013 measurement year.

For this performance indicator, a higher percentage is better, which means that more children and adolescents 3 to 17 years of age did have their BMI calculated and documented during a visit with their primary care provider or OB/GYN.

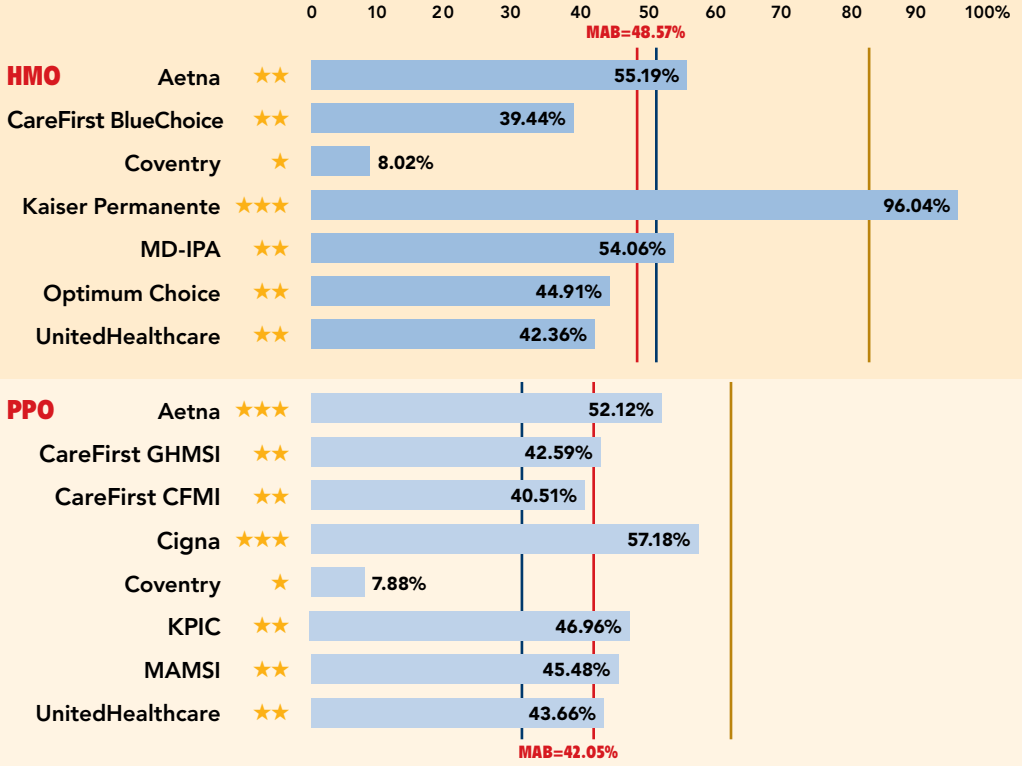
RATIONALE

Obese children are more likely to become obese adults. Screening for obesity begins in the primary care provider's office with the assessment of height and weight in order to calculate body mass index. Medical evaluations should include investigation into possible causes of obesity that may be responsive to treatment such as thyroid gland dysfunction or other issues. Medical evaluations should also include counseling for nutrition and physical activity as well as identification of any obesity related health complications.

Centers for Disease Control and Prevention, 2012

NOTE: There are nine separate indicators in this measure category, including body mass index, nutrition counseling and physical activity counseling for each of three age groupings, 3 to 11 years, 12 to 17 years and 3 to 17 years. Only the total percentage of children and adolescents with documented BMI among the 3 to 17 years of age group is represented in the associated graph.

BODY MASS INDEX – 3 TO 17 YEARS OF AGE



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PERFORMANCE RATING

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BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: HEDIS® Submission or Health Benefit Plan Records

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents

continued

DESCRIPTION

2. The percentage of children and adolescents aged 3 to 17 years in 2013 who had an outpatient visit with a primary care provider or obstetrician/gynecologist (OB/GYN) and whose counseling for nutrition was documented in the 2013 measurement year.

For this performance indicator, a higher percentage is better, which means that more children and adolescents 3 to 17 years of age did receive counseling for nutrition during a visit with their primary care provider or OB/GYN.

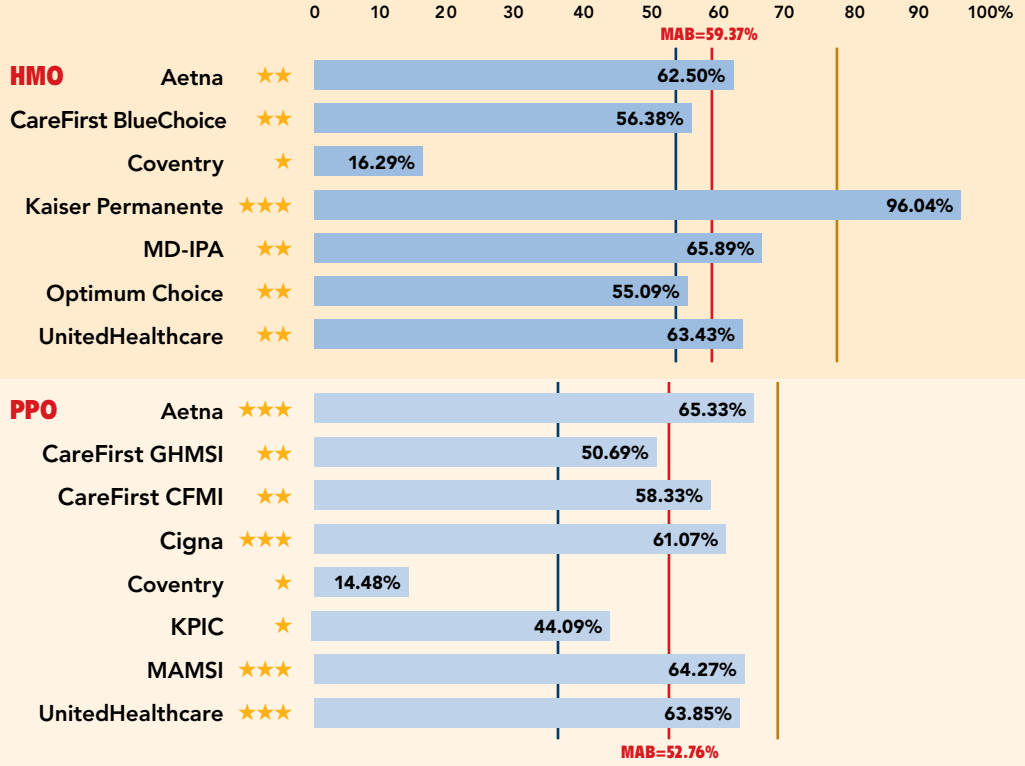
NOTE: There are nine separate indicators in this measure category, including body mass index, nutrition counseling and physical activity counseling for each of three age groupings, 3 to 11 years, 12 to 17 years and 3 to 17 years. Only the total percentage of children and adolescents with documented nutrition counseling among the 3 to 17 years of age group is represented in the associated graph.

RATIONALE

Obese children are more likely to become obese adults. Screening for obesity begins in the primary care provider's office with the assessment of height and weight in order to calculate body mass index. Medical evaluations should include investigation into possible causes of obesity that may be responsive to treatment such as thyroid gland dysfunction or other issues. Medical evaluations should also include counseling for nutrition and physical activity as well as identification of any obesity related health complications.

Centers for Disease Control and Prevention, 2012

NUTRITION COUNSELING – 3 TO 17 YEARS OF AGE



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PERFORMANCE RATING

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BENCHMARKS

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NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: HEDIS® Submission or Health Benefit Plan Records

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents

continued

DESCRIPTION

3. The percentage of children and adolescents aged 3 to 17 years in 2013 who had an outpatient visit with a primary care provider or obstetrician/gynecologist (OB/GYN) and whose counseling for physical activity was documented in the 2013 measurement year.

For this performance indicator, a higher percentage is better, which means that more children and adolescents 3 to 17 years of age did receive counseling for physical activity during a visit with their primary care provider or OB/GYN.

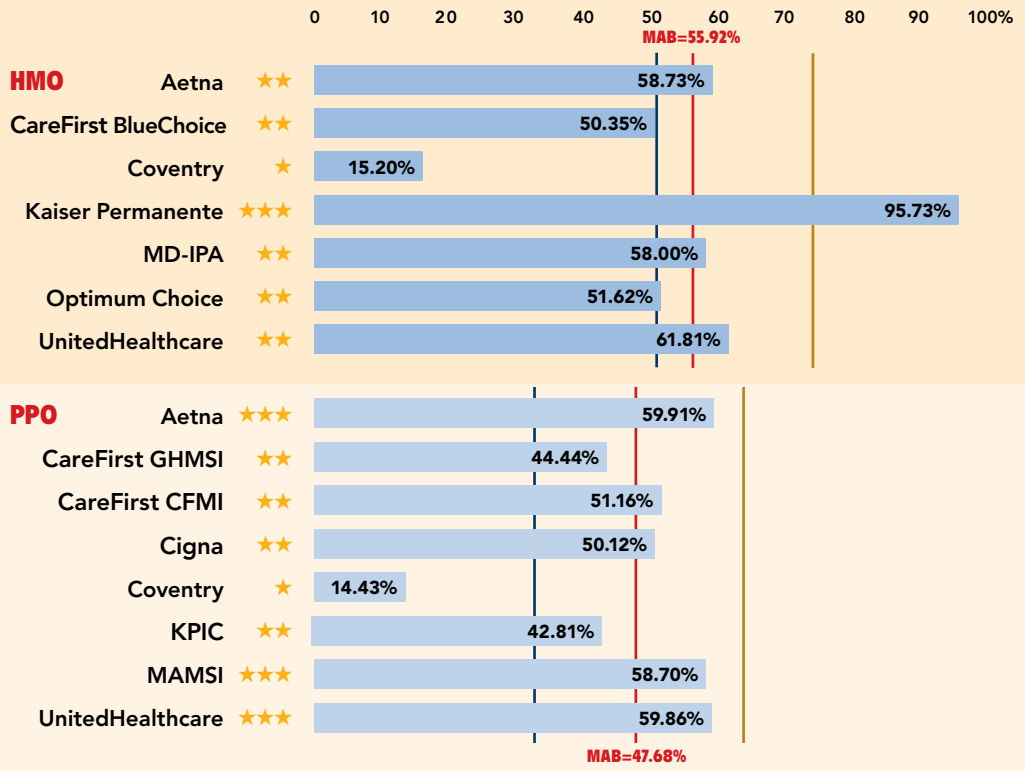
NOTE: There are nine separate indicators in this measure category, including body mass index, nutrition counseling and physical activity counseling for each of three age groupings, 3 to 11 years, 12 to 17 years and 3 to 17 years. Only the total percentage of children and adolescents with documented physical activity counseling among the 3 to 17 years of age group is represented in the associated graph.

RATIONALE

Obese children are more likely to become obese adults. Screening for obesity begins in the primary care provider's office with the assessment of height and weight in order to calculate body mass index. Medical evaluations should include investigation into possible causes of obesity that may be responsive to treatment such as thyroid gland dysfunction or other issues. Medical evaluations should also include counseling for nutrition and physical activity as well as identification of any obesity related health complications.

Centers for Disease Control and Prevention, 2012

PHYSICAL ACTIVITY COUNSELING – 3 TO 17 YEARS OF AGE



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BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: HEDIS® Submission or Health Benefit Plan Records

Follow-Up Care for Children Prescribed ADHD Medication

DESCRIPTION

Each health benefit plan reports on multiple indicators under this measure. Two separate indicators include:

1. Initiation Phase: The percentage of children aged 6 to 12 years during the intake period from March 1, 2013 to February 28, 2014 that were newly prescribed attention deficit/ hyperactivity disorder (ADHD) medication, who also had one follow-up visit with a practitioner with prescribing authority during the initial 30 days of when the first ADHD medication was prescribed (Index Prescription Start Date).

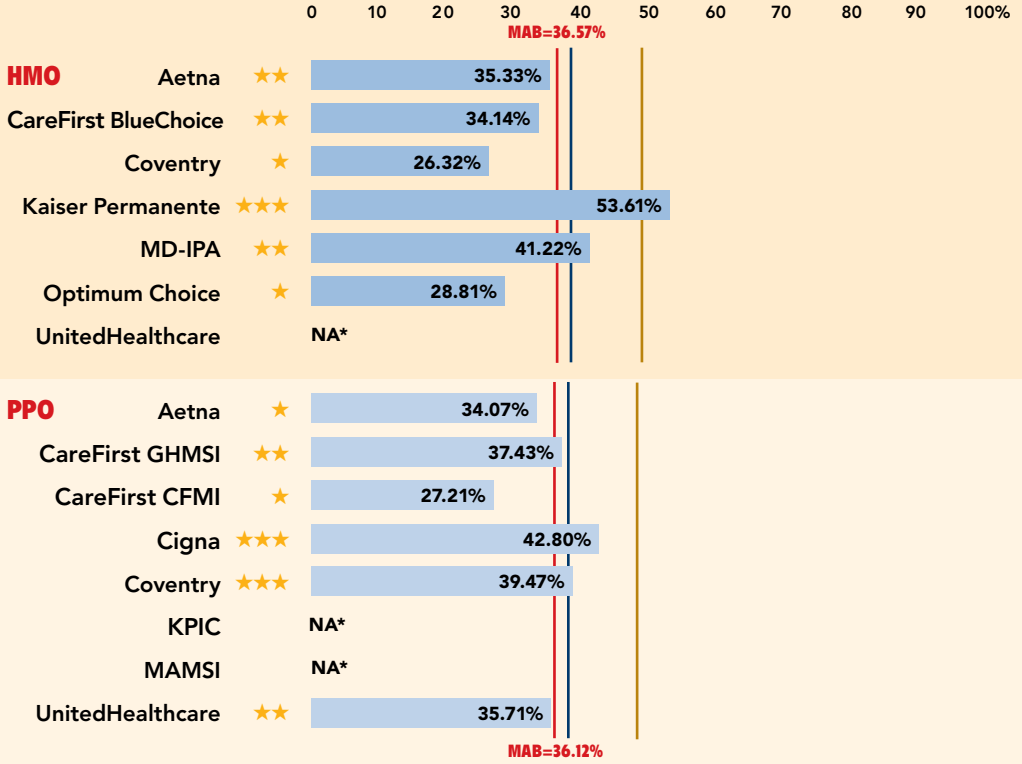
For this performance indicator, a higher percentage is better, which means that more children 6 to 12 years of age did have a follow-up visit during the 30-day Initiation Phase.

RATIONALE

Attention deficit/hyperactivity disorder (ADHD) is one of the more common chronic childhood conditions. Children with ADHD may experience significant functional and behavioral problems, such as school difficulties, academic underachievement and trouble maintaining relationships with family members and peers. Effective medications are available to treat ADHD. It should be noted that while not always recommended, there have also been some cases of "drug holidays" from ADHD medications taken by children when the child is out of school for extended periods, such as during weekends or the summer.

National Center for Biotechnology Information
U.S. National Library of Medicine
National Institutes of Health

INITIATION PHASE – 6 TO 12 YEARS OF AGE



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PERFORMANCE RATING

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BENCHMARKS

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NTP (NATIONAL TOP PERFORMERS)

NA* Insufficient eligible members (fewer than 30) to calculate rate

Data Source: HEDIS® Submission or Health Benefit Plan Records

Follow-Up Care for Children Prescribed ADHD Medication continued

DESCRIPTION

2. Continuation and Maintenance Phase: The percentage of children aged 6 to 12 years during the intake period from March 1, 2013 to February 28, 2014 that were newly prescribed attention deficit/hyperactivity disorder (ADHD) medication, who remained on the medication for at least a 7-month period (210 days) and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner with prescribing authority within 9 months (270 days) after the 30-day Initiation Phase ended.

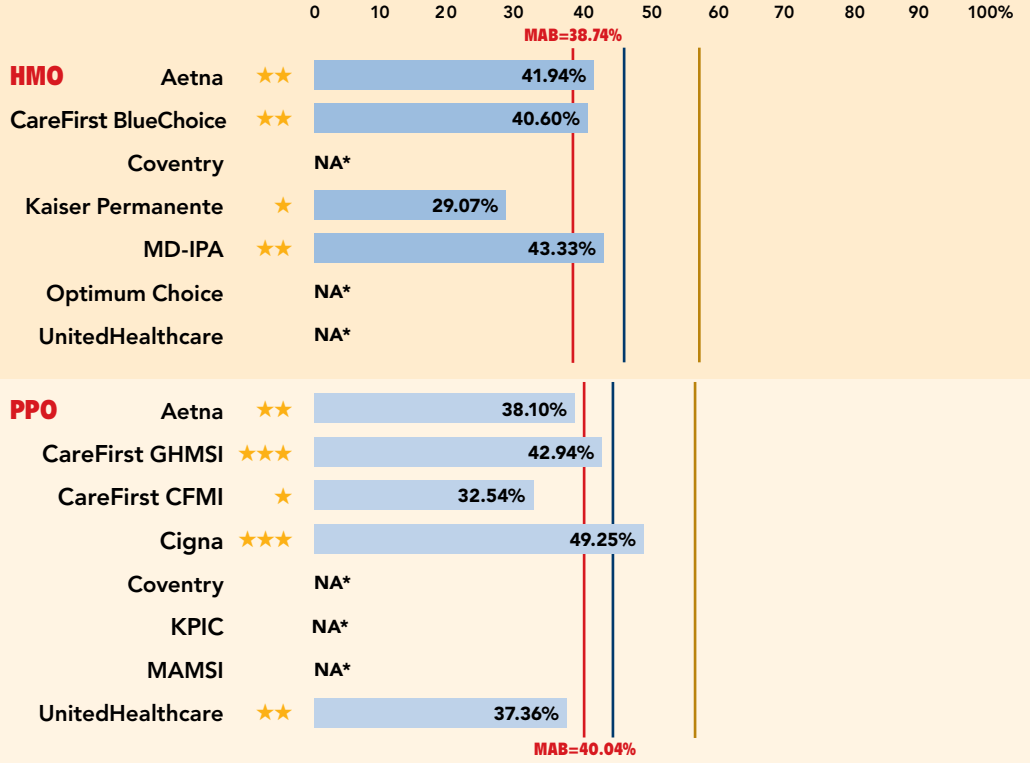
For this performance indicator, a higher percentage is better, which means that more children 6 to 12 years of age did have at least two additional follow-up visits over the 9 month period following the end of the 30-day Initiation Phase.

RATIONALE

Attention deficit/hyperactivity disorder (ADHD) is one of the more common chronic childhood conditions. Children with ADHD may experience significant functional and behavioral problems, such as school difficulties, academic underachievement and trouble maintaining relationships with family members and peers. Effective medications are available to treat ADHD. It should be noted that while not always recommended, there have also been some cases of "drug holidays" from ADHD medications taken by children when the child is out of school for extended periods, such as during weekends or the summer.

National Center for Biotechnology Information
U.S. National Library of Medicine
National Institutes of Health

CONTINUATION & MAINTENANCE PHASE – 6 TO 12 YEARS OF AGE



More stars indicate better health benefit plan performance.

The "stars" represent the relative comparisons between the health benefit plans and the Maryland Average Benchmark.

PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

NA* Insufficient eligible members (fewer than 30) to calculate rate

Data Source: HEDIS® Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Child Respiratory Conditions

The excess use of antibiotics in the treatment of children with upper respiratory infections and the under use of controller medications in the treatment of children with asthma can lead to an overall lowering of quality of life and an increase in health care costs. Within the last decade, a push toward responsible antibiotic stewardship is helping to curb the nation's excess use of antibiotics which leads to the shared problem of antibiotic resistance. In addition, a push toward the appropriate use of asthma controller medications which decrease the need for use of emergency medications for asthma, are helping to control the rising cost of care.

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

CHILD RESPIRATORY CONDITIONS

Appropriate Testing for Children with Pharyngitis

DESCRIPTION

The percentage of children and adolescents aged 2 to 18 years in 2013 who after receiving group-A streptococcus (strep) test, were diagnosed with pharyngitis and then given an appropriate prescription for an antibiotic.

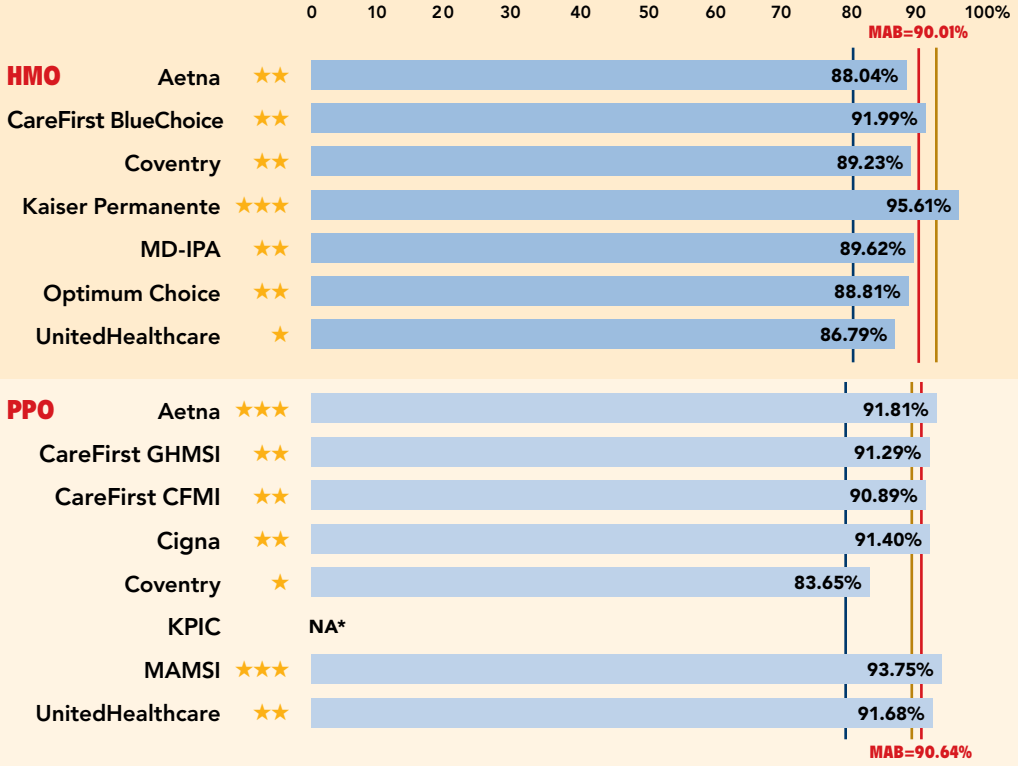
For this measure, a higher percentage is better, which means that more children and adolescents 2 to 18 years of age received appropriate strep testing before beginning antibiotic treatment for pharyngitis.

RATIONALE

The definitive diagnosis of pharyngitis, commonly referred to as strep throat, should not be made without simple laboratory testing. Commonly used laboratory tests for diagnosing strep throat include the rapid antigen detection test (RADT), which takes only minutes to get results, and the throat culture, which can take a day or two to get results. Clinical practice guidelines recommend that antibiotics are prescribed only when the diagnosis of group-A strep pharyngitis is based on the RADT or throat culture laboratory tests.

U.S. National Library of Medicine, 2014
National Institutes of Health
U.S. Department of Health and Human Service

GROUP-A STREP TEST – 2 TO 18 YEARS OF AGE



More stars indicate better health benefit plan performance.

The "stars" represent the relative comparisons between the health benefit plans and the Maryland Average Benchmark.

PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

NA* Insufficient eligible members (fewer than 30) to calculate rate

Data Source: HEDIS® Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

CHILD RESPIRATORY CONDITIONS

Appropriate Treatment for Children with Upper Respiratory Infection

DESCRIPTION

The percentage of infants, children and adolescents aged 3 months to 18 years in 2013 who were given a diagnosis of upper respiratory infection (URI) and were appropriately not given an antibiotic prescription within three days of their visit.

For this measure, a higher percentage is better, which means that more infants, children and adolescents 3 months to 18 years of age appropriately did not get an antibiotic prescription to treat an URI.

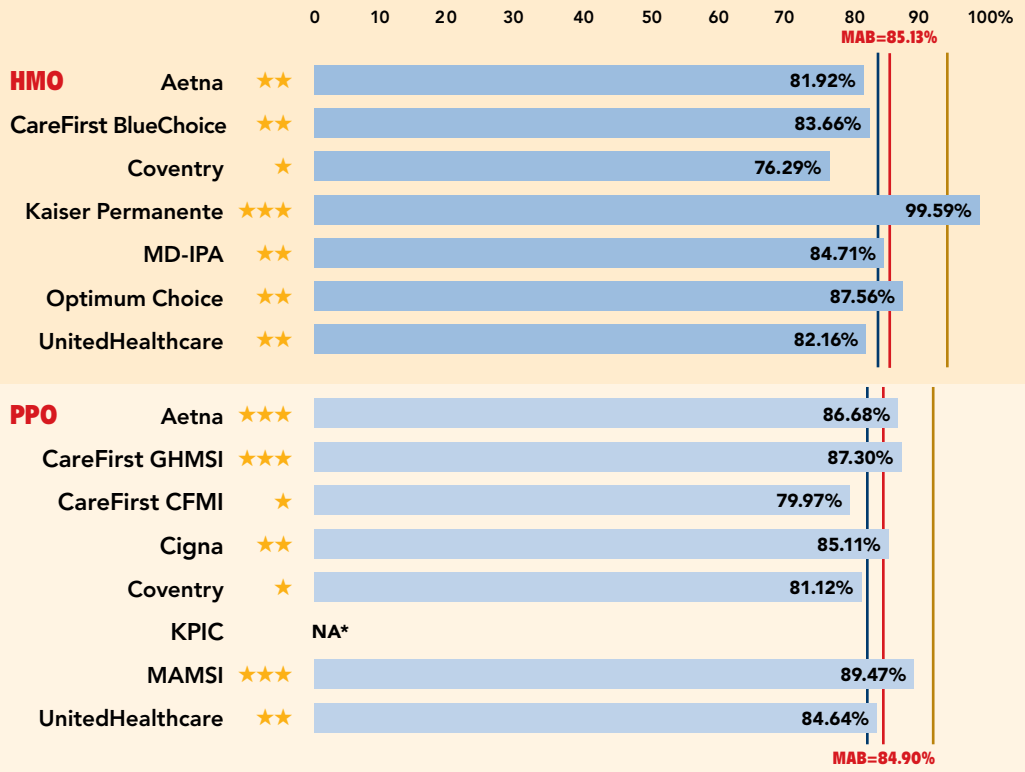
RATIONALE

The common cold is an upper respiratory infection (URI) that is a frequent reason for children visiting the doctor's office. Existing clinical practice guidelines do not support the use of antibiotics for the majority of upper respiratory infections including the common cold due to the viral cause of many of these infections.

The prevalence of inappropriate antibiotic prescribing in clinical practice raises awareness of the importance of reducing inappropriate antibiotic use in order to combat antibiotic resistance in the community.

National Center for Immunization and Respiratory Diseases, 2013 Centers for Disease Control and Prevention

APPROPRIATELY NOT PRESCRIBED ANTIBIOTICS – 3 MONTHS TO 18 YEARS OF AGE



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PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
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★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

NA* Insufficient eligible members (fewer than 30) to calculate rate

Data Source: HEDIS® Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

CHILD RESPIRATORY CONDITIONS

Use of Appropriate Medications for Children with Asthma

DESCRIPTION

Each health benefit plan reports on multiple indicators under this measure. Two separate indicators include:

1. The percentage of children aged 5 to 11 years in 2013 who were identified as having persistent asthma and who were appropriately prescribed asthma controller or reliever/rescue medication during the measurement year.

For this performance indicator, a higher percentage is better, which means that more children 5 to 11 years of age with asthma were appropriately prescribed asthma medications.

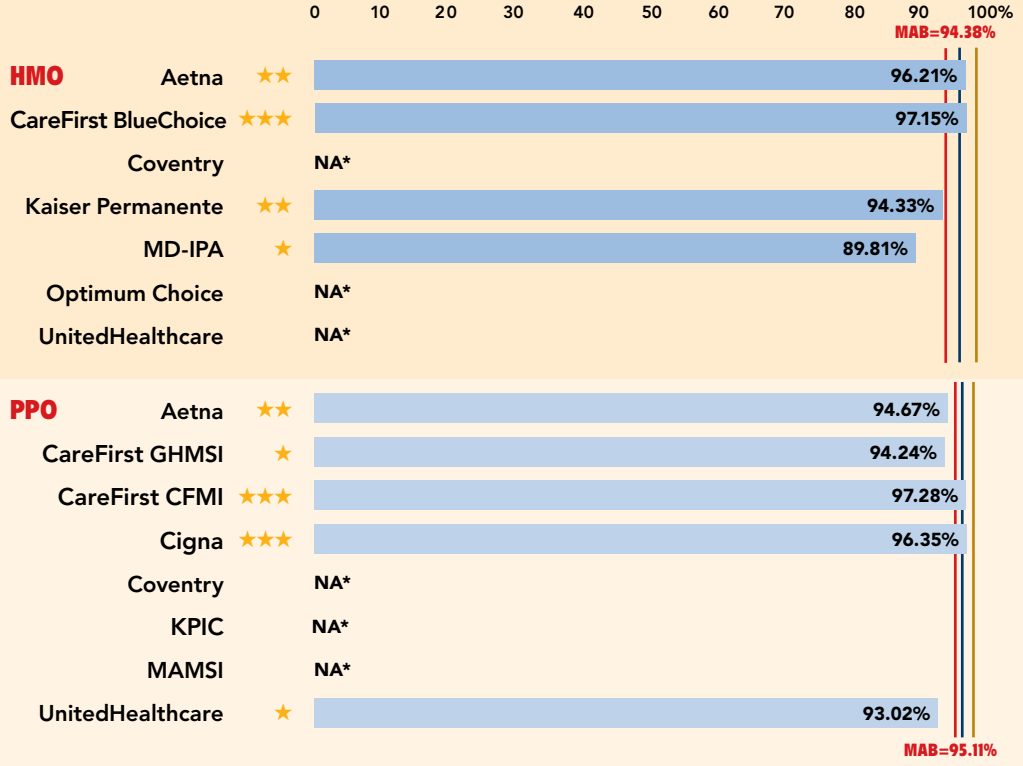
NOTE: Please find adults 19 to 50 and 51 to 64 years of age in the Primary Care for Adults – Respiratory Conditions section.

RATIONALE

Asthma is one of the nation's most costly and widespread diseases affecting children and adults alike. Approximately 7 million children have been diagnosed with asthma and each year more than 3,000 people in the United States die of it. Many asthma-related hospitalizations, emergency room visits and missed work and school days can be avoided if patients have appropriate medications and medical management. Appropriate medications help reduce underlying airway inflammation and relieve or prevent airway narrowing.

National Center for Health Statistics, 2011
Centers for Disease Control and Prevention

APPROPRIATE ASTHMA MEDICATIONS – 5 TO 11 YEARS OF AGE



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PERFORMANCE RATING

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BENCHMARKS

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Data Source: HEDIS® Submission or Health Benefit Plan Records

Use of Appropriate Medications for Children with Asthma continued

DESCRIPTION

2. The percentage of adolescents aged 12 to 18 years in 2013 who were identified as having persistent asthma and who were appropriately prescribed asthma controller or reliever/ rescue medications.

For this performance indicator, a higher percentage is better, which means that more adolescents 12 to 18 years of age with asthma were appropriately prescribed asthma medications.

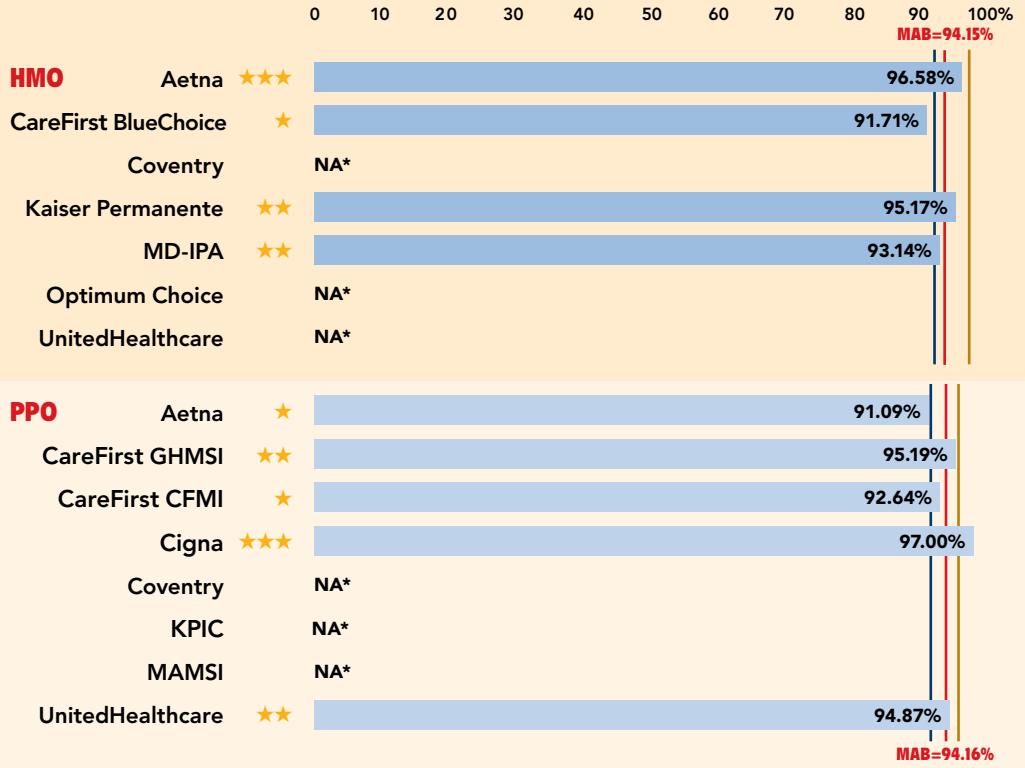
NOTE: Please find adults 19 to 50 and 51 to 64 years of age in the Primary Care for Adults – Respiratory Conditions section.

RATIONALE

Asthma is one of the nation's most costly and widespread diseases affecting children and adults alike. Approximately 7 million children have been diagnosed with asthma and each year more than 3,000 people in the United States die of it. Many asthma-related hospitalizations, emergency room visits and missed work and school days can be avoided if patients have appropriate medications and medical management. Appropriate medications help reduce underlying airway inflammation and relieve or prevent airway narrowing.

National Center for Health Statistics, 2011
Centers for Disease Control and Prevention

APPROPRIATE ASTHMA MEDICATIONS – 12 TO 18 YEARS OF AGE



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PERFORMANCE RATING

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BENCHMARKS

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Data Source: HEDIS® Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

CHILD RESPIRATORY CONDITIONS

Asthma Medication Ratio

DESCRIPTION

Each health benefit plan reports on multiple indicators under this measure. Two separate indicators include:

1. The percentage of children aged 5 to 11 years in 2013 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the 2013 measurement year.

For this performance indicator, a higher percentage is better, which means that more children 5 to 11 years of age with asthma were prescribed asthma controller medications at least as often as reliever/ rescue medications.

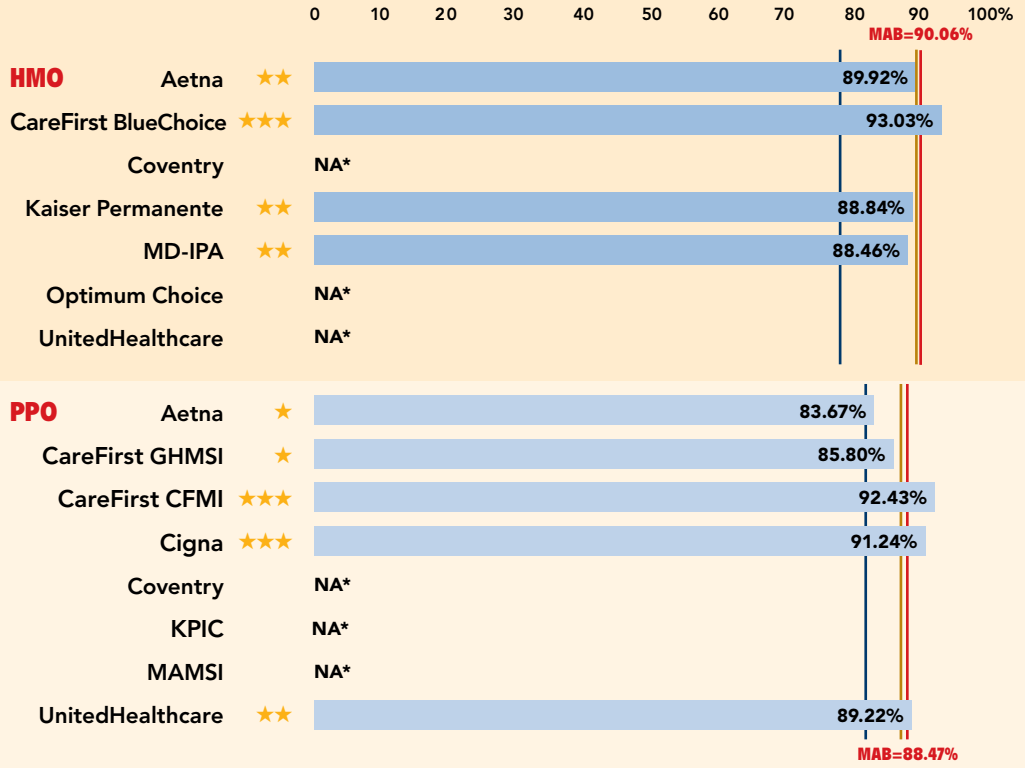
NOTE: Please find adults 19 to 50 and 51 to 64 years of age in the Primary Care for Adults – Respiratory Conditions section.

RATIONALE

Asthma is one of the nation's most costly and widespread diseases affecting children and adults alike. Approximately 7 million children have been diagnosed with asthma and each year more than 3,000 people in the United States die of it. Many asthma-related hospitalizations, emergency room visits and missed work and school days can be avoided if patients have appropriate medications and medical management. Appropriate medications help reduce underlying airway inflammation and relieve or prevent airway narrowing.

National Center for Health Statistics, 2011
Centers for Disease Control and Prevention

ASTHMA CONTROLLER MEDICATION RATIO ≥50% – 5 TO 11 YEARS OF AGE



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PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
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BENCHMARKS

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NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

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Data Source: HEDIS® Submission or Health Benefit Plan Records

Asthma Medication Ratio continued

DESCRIPTION

2. The percentage of adolescents aged 12 to 18 years in 2013 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the 2013 measurement year.

For this performance indicator, a higher percentage is better, which means that more adolescents 12 to 18 years of age with asthma were prescribed asthma controller medications at least as often as reliever/rescue medications.

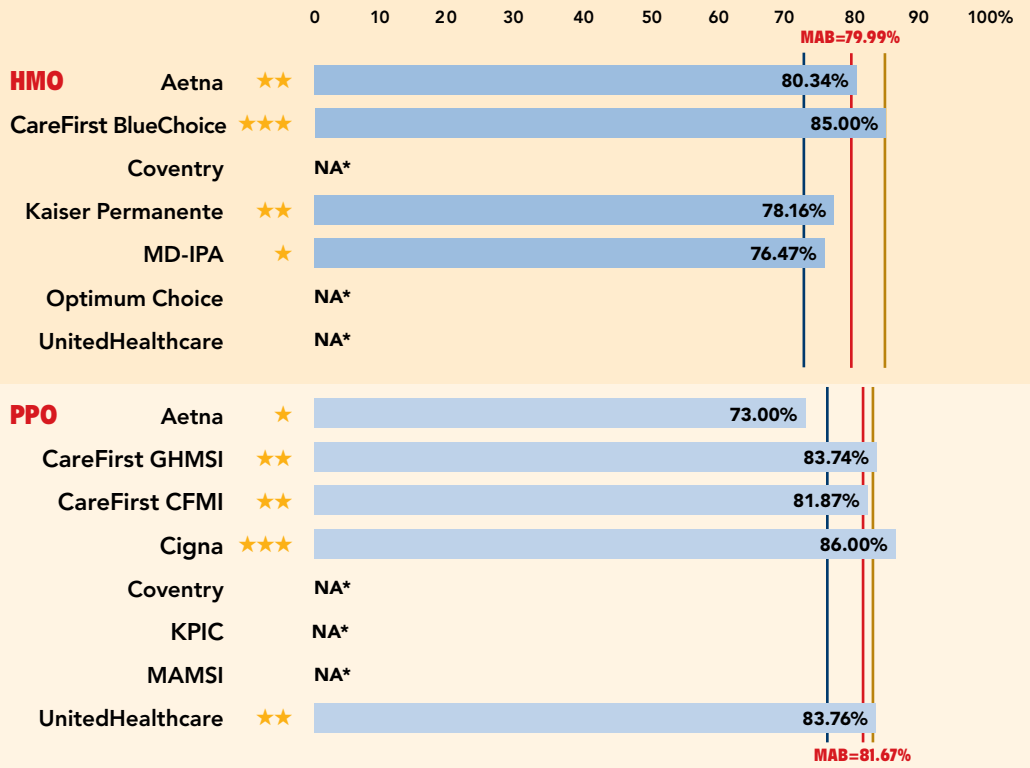
NOTE: Please find adults 19 to 50 and 51 to 64 years of age in the Primary Care for Adults – Respiratory Conditions section.

RATIONALE

Asthma is one of the nation's most costly and widespread diseases affecting children and adults alike. Approximately 7 million children have been diagnosed with asthma and each year more than 3,000 people in the United States die of it. Many asthma-related hospitalizations, emergency room visits and missed work and school days can be avoided if patients have appropriate medications and medical management. Appropriate medications help reduce underlying airway inflammation and relieve or prevent airway narrowing.

National Center for Health Statistics, 2011
Centers for Disease Control and Prevention

ASTHMA CONTROLLER MEDICATION RATIO ≥50% – 12 TO 18 YEARS OF AGE



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PERFORMANCE RATING

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Data Source: HEDIS® Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

CHILD RESPIRATORY CONDITIONS

Medication Management for Children with Asthma

DESCRIPTION

Each health benefit plan reports on multiple indicators under this measure. Four separate indicators include:

1. The percentage of children aged 5 to 11 years in 2013 who were identified as having persistent asthma, were given a prescription for an appropriate medication including an asthma controller or reliever/rescue medication, and who remained on that medication for at least 50 percent of the remaining days in 2013.

For this performance indicator, a higher percentage is better, which means that more children 5 to 11 years of age with asthma remained compliant on their asthma medication for at least 50 percent of the treatment period.

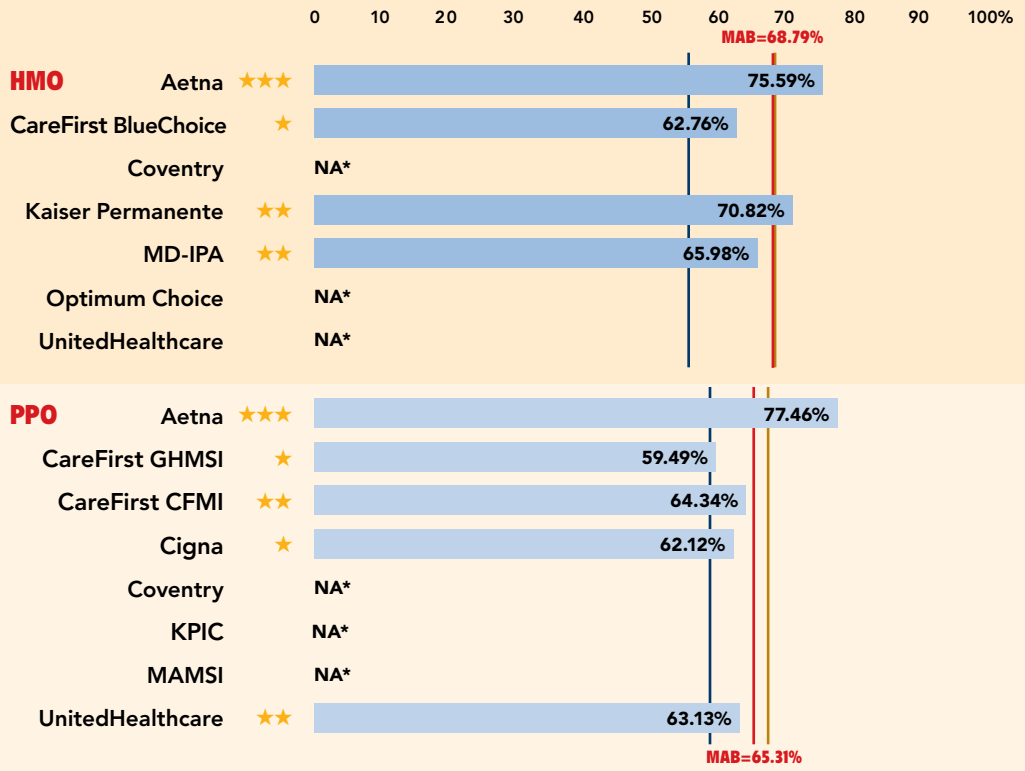
NOTE: Please find adults 19 to 50 and 51 to 64 years of age in the Primary Care for Adults – Respiratory Conditions section.

RATIONALE

Asthma is one of the nation's most costly and widespread diseases affecting children and adults alike. Approximately 7 million children have been diagnosed with asthma and each year more than 3,000 people in the United States die of it. Many asthma-related hospitalizations, emergency room visits and missed work and school days can be avoided if patients have appropriate medications and medical management. Appropriate medications help reduce underlying airway inflammation and relieve or prevent airway narrowing.

National Center for Health Statistics, 2011
Centers for Disease Control and Prevention

50% TREATMENT COMPLIANCE – 5 TO 11 YEARS OF AGE



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PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
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BENCHMARKS

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NTP (NATIONAL TOP PERFORMERS)

NA* Insufficient eligible members (fewer than 30) to calculate rate

Data Source: HEDIS® Submission or Health Benefit Plan Records

Medication Management for Children with Asthma
continued

DESCRIPTION

2. The percentage of adolescents aged 12 to 18 years in 2013 who were identified as having persistent asthma, were given a prescription for an appropriate medication including an asthma controller or reliever/rescue medication, and who remained on that medication for at least 50 percent of the remaining days in 2013.

For this performance indicator, a higher percentage is better, which means that more adolescents 12 to 18 years of age with asthma remained compliant on their asthma medication for at least 50 percent of the treatment period.

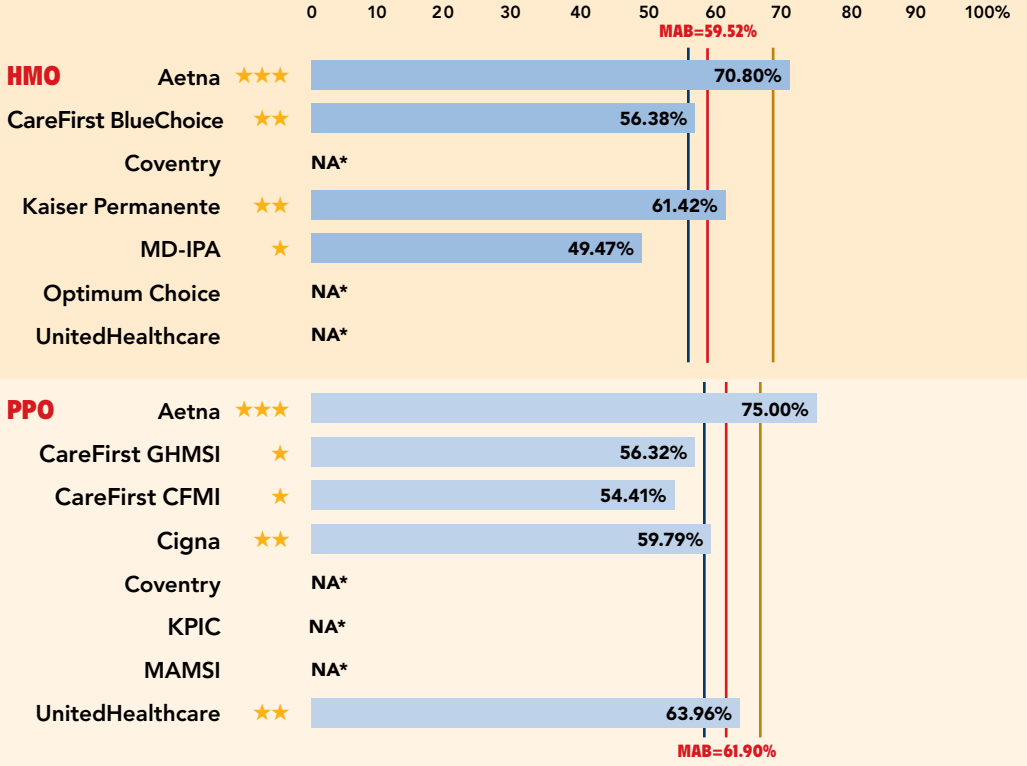
NOTE: Please find adults 19 to 50 and 51 to 64 years of age in the Primary Care for Adults – Respiratory Conditions section.

RATIONALE

Asthma is one of the nation's most costly and widespread diseases affecting children and adults alike. Approximately 7 million children have been diagnosed with asthma and each year more than 3,000 people in the United States die of it. Many asthma-related hospitalizations, emergency room visits and missed work and school days can be avoided if patients have appropriate medications and medical management. Appropriate medications help reduce underlying airway inflammation and relieve or prevent airway narrowing.

National Center for Health Statistics, 2011
Centers for Disease Control and Prevention

50% TREATMENT COMPLIANCE – 12 TO 18 YEARS OF AGE



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PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

NA* Insufficient eligible members (fewer than 30) to calculate rate

Data Source: HEDIS® Submission or Health Benefit Plan Records

Medication Management for Children with Asthma
continued

DESCRIPTION

3. The percentage of children aged 5 to 11 years in 2013 who were identified as having persistent asthma, were given a prescription for an appropriate medication including an asthma controller or reliever/rescue medication, and who remained on that medication for at least 75 percent of the remaining days in 2013.

For this performance indicator, a higher percentage is better, which means that more children 5 to 11 years of age with asthma remained compliant on their asthma medication for at least 75 percent of the treatment period.

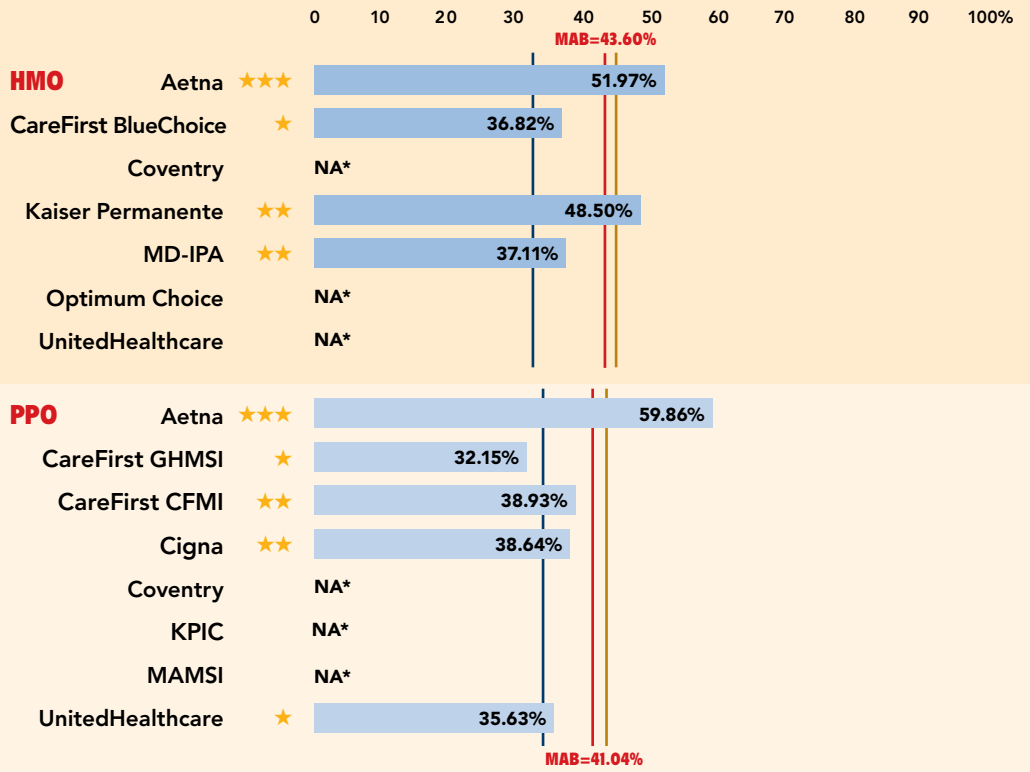
NOTE: Please find adults 19 to 50 and 51 to 64 years of age in the Primary Care for Adults – Respiratory Conditions section.

RATIONALE

Asthma is one of the nation's most costly and widespread diseases affecting children and adults alike. Approximately 7 million children have been diagnosed with asthma and each year more than 3,000 people in the United States die of it. Many asthma-related hospitalizations, emergency room visits and missed work and school days can be avoided if patients have appropriate medications and medical management. Appropriate medications help reduce underlying airway inflammation and relieve or prevent airway narrowing.

National Center for Health Statistics, 2011
Centers for Disease Control and Prevention

75% TREATMENT COMPLIANCE – 5 TO 11 YEARS OF AGE



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PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
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BENCHMARKS

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NTP (NATIONAL TOP PERFORMERS)

NA* Insufficient eligible members (fewer than 30) to calculate rate

Data Source: HEDIS® Submission or Health Benefit Plan Records

Medication Management for Children with Asthma
continued

DESCRIPTION

4. The percentage of adolescents aged 12 to 18 years in 2013 who were identified as having persistent asthma, were given a prescription for an appropriate medication including an asthma controller or reliever/rescue medication, and who remained on that medication for at least 75 percent of the remaining days in 2013.

For this performance indicator, a higher percentage is better, which means that more adolescents 12 to 18 years of age with asthma remained compliant on their asthma medication for at least 75 percent of the treatment period.

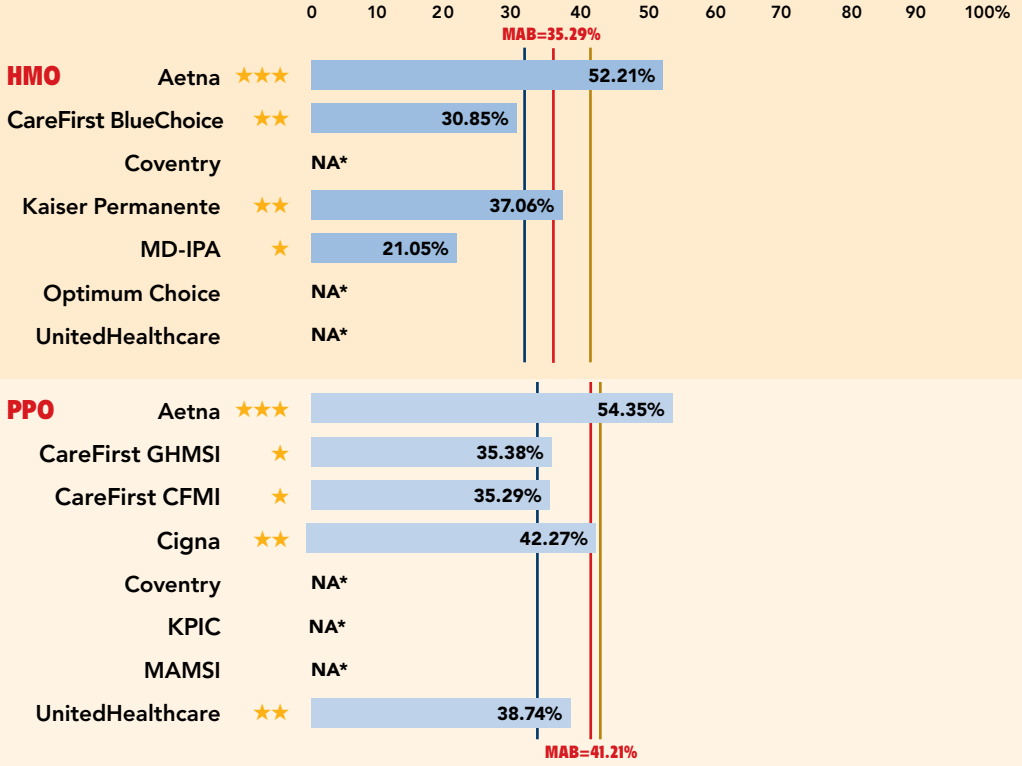
NOTE: Please find adults 19 to 50 and 51 to 64 years of age in the Primary Care for Adults – Respiratory Conditions section.

RATIONALE

Asthma is one of the nation's most costly and widespread diseases affecting children and adults alike. Approximately 7 million children have been diagnosed with asthma and each year more than 3,000 people in the United States die of it. Many asthma-related hospitalizations, emergency room visits and missed work and school days can be avoided if patients have appropriate medications and medical management. Appropriate medications help reduce underlying airway inflammation and relieve or prevent airway narrowing.

National Center for Health Statistics, 2011
Centers for Disease Control and Prevention

75% TREATMENT COMPLIANCE – 12 TO 18 YEARS OF AGE



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PERFORMANCE RATING

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BENCHMARKS

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IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Women's Health

Prevention and early detection of illness lead to the availability of more treatment choices and better health outcomes for patients as well as lower overall costs of care. Preventive care, such as prenatal and postpartum care for women, as well as early detection programs including screenings for cancer and other illnesses can lead to a higher probability of survival for affected women and a healthier infant population.

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

WOMEN'S HEALTH

Prenatal and Postpartum Care

DESCRIPTION

Each health benefit plan reports on multiple indicators under this measure. Two separate indicators include:

1. Timeliness of Prenatal Care: The percentage of women with live birth deliveries during the treatment period between November 6th, 2012 and November 5th, 2013, who had a prenatal care visit in their first trimester of pregnancy or within 42 days of enrollment in the health benefit plan.

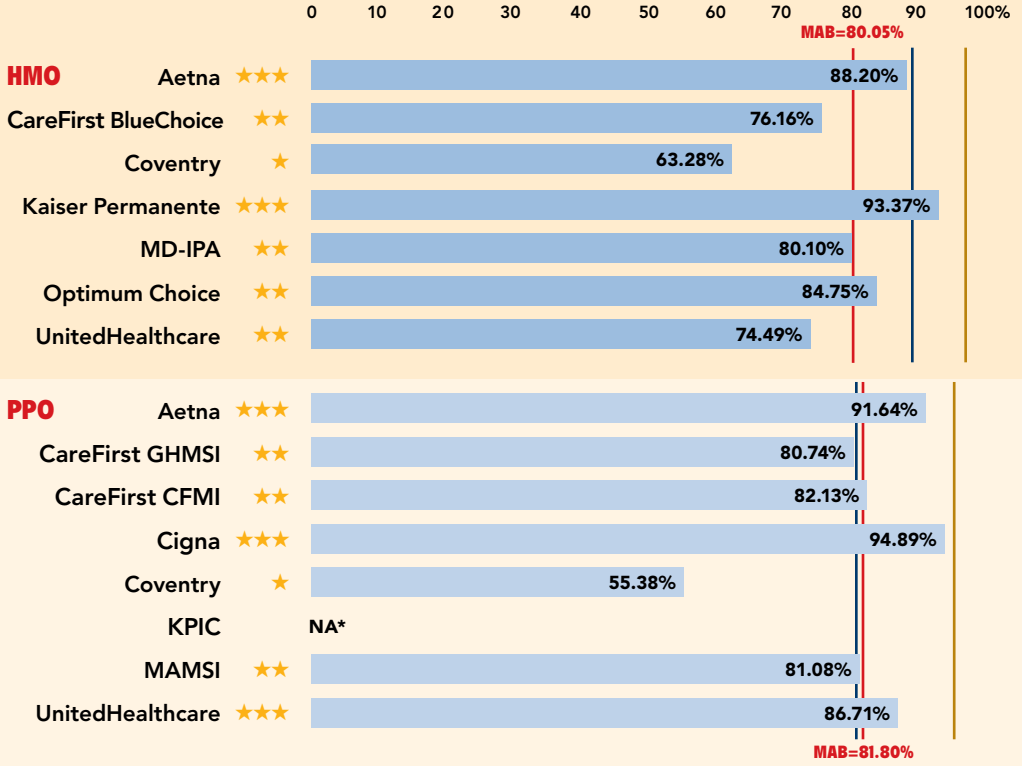
For this performance indicator, a higher percentage is better, which means that more women with live birth deliveries did receive timely prenatal care.

RATIONALE

Prenatal care involves medical checkups that include education and counseling about how to handle the different aspects of pregnancy, and laboratory testing that screens for signs of possible health problems for mom or baby(ies). Based on screening test results, additional diagnostic testing may be necessary to confirm or rule out health problems. It is essential for prenatal care to begin early in pregnancy in order for resulting interventions to have an optimal effect on health outcomes for mom and baby(ies). Ideally, a pregnant woman will have her first prenatal visit during the first trimester of pregnancy.

Office of Women's Health, 2010
Office of the Assistant Secretary for Health
U.S. Department of Health and Human Services

TIMELY PRENATAL CARE – 1ST TRIMESTER OF PREGNANCY OR 0 TO 42 DAYS OF ENROLLMENT



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PERFORMANCE RATING

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BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

NA* Insufficient eligible members (fewer than 30) to calculate rate

Data Source: HEDIS® Submission or Health Benefit Plan Records

Prenatal and Postpartum Care continued

DESCRIPTION

2. Timeliness of Postpartum Care: The percentage of women with live birth deliveries during the treatment period between November 6th, 2012 and November 5th, 2013, who had a postpartum care visit on or between 21 to 56 days after a live birth delivery.

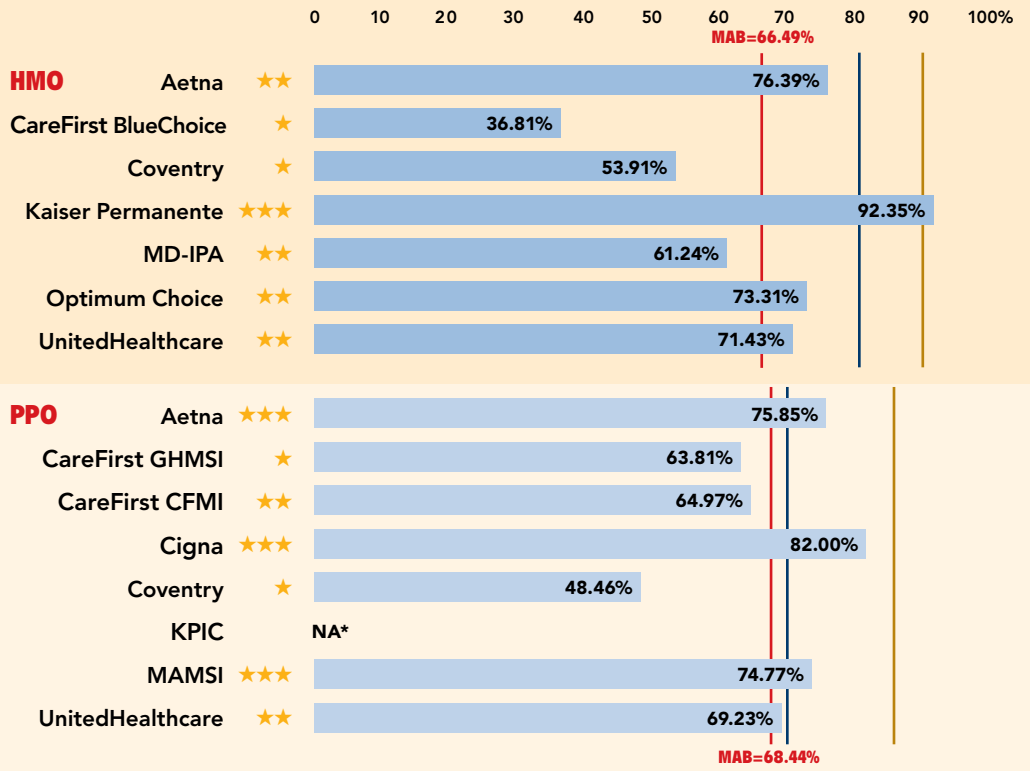
For this performance indicator, a higher percentage is better, which means that more women with live birth deliveries did receive timely postpartum care.

RATIONALE

Pregnancy-related changes to a woman's body continue after labor and delivery. Postpartum care is important after a vaginal delivery or a cesarean section delivery. The first postpartum visit should include a physical examination and an opportunity for the health care practitioner to answer questions and give family planning guidance and counseling on nutrition.

Office on Women's Health, 2010
Office of the Assistant Secretary of Health
U.S. Department of Health and Human Services

TIMELY POSTPARTUM CARE – 21 TO 56 DAYS AFTER DELIVERY



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PERFORMANCE RATING

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BENCHMARKS

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Data Source: HEDIS® Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

WOMEN'S HEALTH

Breast Cancer Screening

DESCRIPTION

The percentage of women aged 50 to 74 years in 2013 who were continuously enrolled with the health benefit plan from October 1, 2011 through December 31, 2013, who also had at least 1 mammogram to screen for breast cancer during the same time period.

For this measure, a higher percentage is better, which means that more women did get a mammogram within the required timeframe.

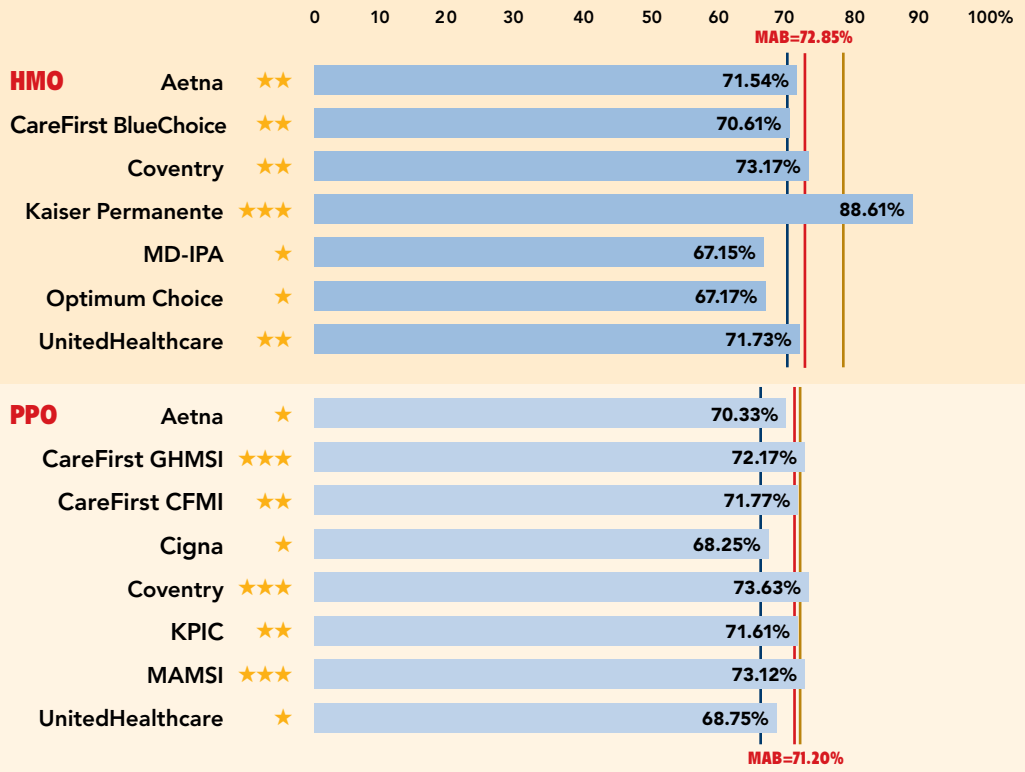
NOTE: Some of the quality measures related to women's health are subject to revision and update based on current research and clinical guidelines. The Breast Cancer Screening measure is one quality measure that is being considered for revision by the National Committee for Quality Assurance, due to recent findings concerning the recommended frequency for mammograms and the age groups most impacted.

RATIONALE

Breast cancer is the second leading cause of death from cancer among American women. Women whose breast cancer is detected early, through a mammogram or other breast exam, have more treatment choices and better chances for survival. Clinical guidelines previously indicated that women should begin annual mammogram screening at the age of 40. Currently, not all organizations agree about when mammogram screening should begin or how frequently it should be conducted. Therefore, it is recommended that women discuss the benefits and risks with their health care provider, and together decide the right course of action.

National Cancer Institute, 2014
National Institutes of Health

1+ MAMMOGRAM – 50 TO 74 YEARS OF AGE



More stars indicate better health benefit plan performance.

The "stars" represent the relative comparisons between the health benefit plans and the Maryland Average Benchmark.

PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: HEDIS® Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

WOMEN'S HEALTH

Cervical Cancer Screening

DESCRIPTION

Health benefit plans report their performance for this measure using either of two appropriate cervical cancer screening methods:

- The percentage of women aged 21 to 64 years in 2013 who were continuously enrolled with the plan during the 2013 measurement year and the two years prior, who also received one or more Pap smear tests to screen for cervical cancer during the three year period.
- The percentage of women aged 30 to 64 years in 2013 who were continuously enrolled with the plan during the 2013 measurement year and the four years prior, who also received one or more Pap smear and HPV co-tests to screen for cervical cancer during the five year period.

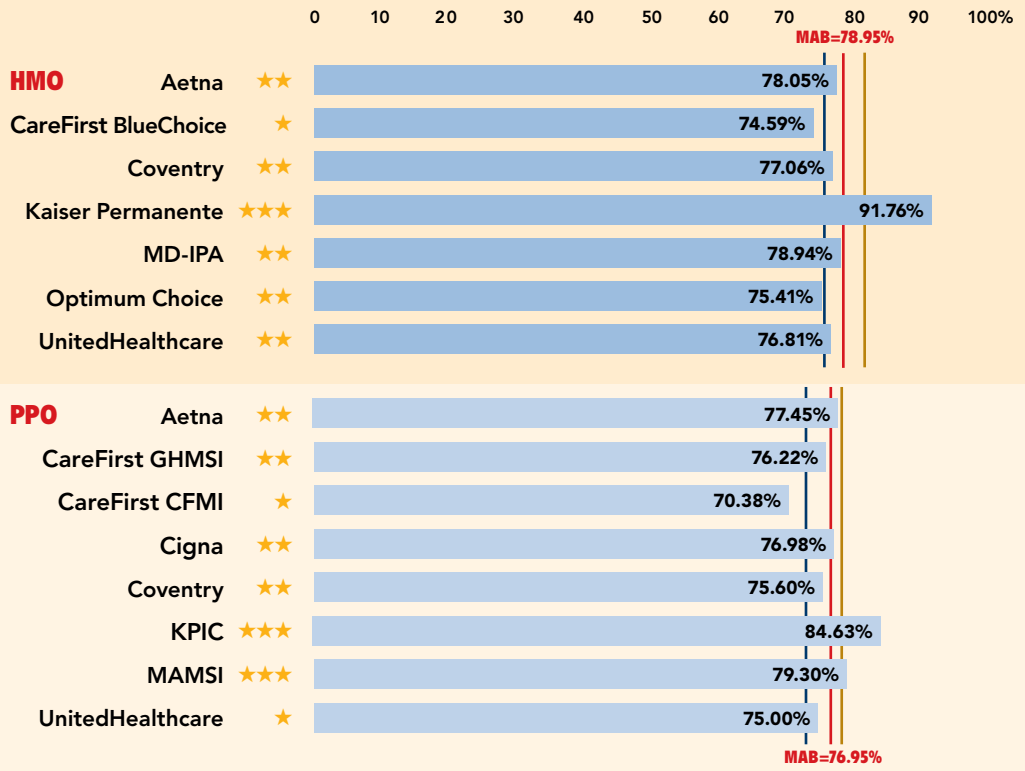
For this measure, a higher percentage is better, which means that more women did get the recommended Pap smear or co-testing performed.

RATIONALE

Cervical cancer is the second or third most common type of cancer among women worldwide. In some countries it is the most common type of cancer. In the United States, cervical cancer occurs most often among minority women, particularly Asian-American, Alaska native and Hispanic women. The chance of dying of cervical cancer increases as women get older. Women who have never had a Pap test or who have not had one for several years have a higher than average risk of developing cervical cancer. Most importantly, when detected and treated early, cervical cancer is one of the most treatable cancers.

Agency for Healthcare Research and Quality, 2011
U.S. Department of Health and Human Services

1+ CERVICAL CANCER SCREENING – 21 TO 64 YEARS OF AGE



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BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: HEDIS® Submission or Health Benefit Plan Records

Chlamydia Screening

DESCRIPTION

The percentage of women aged 16 to 24 years in 2013 who were identified as sexually active and who had at least one test for chlamydia during the 2013 measurement year.

For this measure, a higher percentage is better, which means that more women 16 to 24 years of age did get at least one chlamydia screening test.

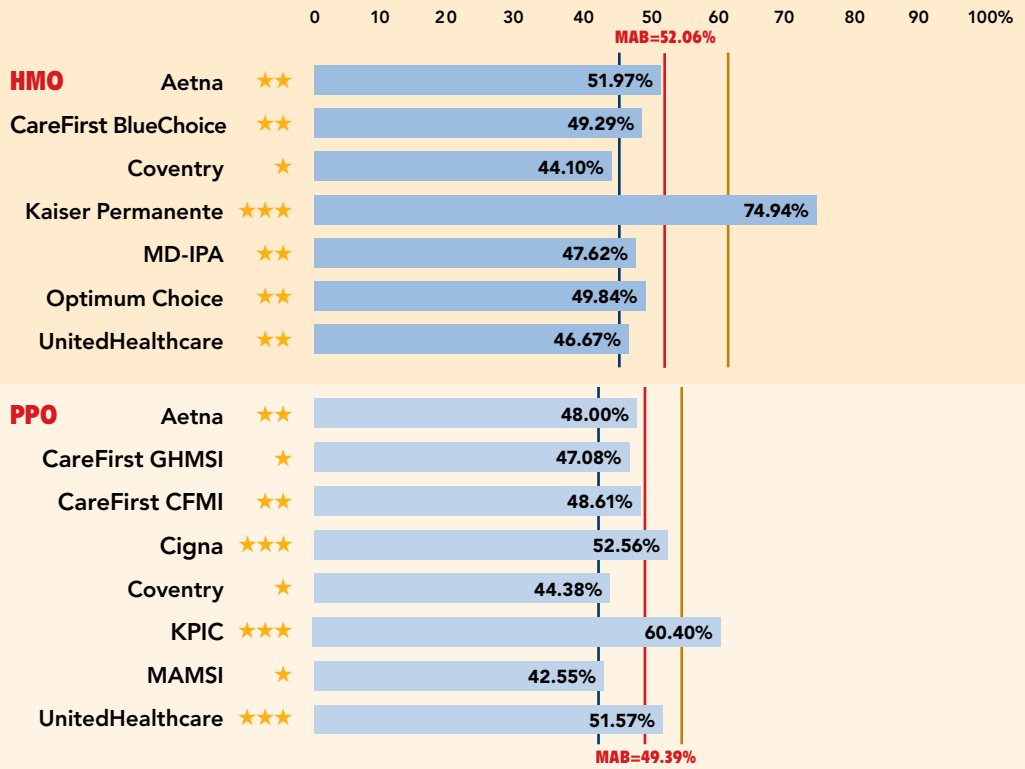
NOTE: There are three separate indicators in this measure category including chlamydia screening among women 16 to 20 years, 21 to 24 years and 16 to 24 years. Only the total percentage of women screened among the 16 to 24 years age group is represented in the associated graph.

RATIONALE

Chlamydia is a common bacterial sexually transmitted disease (STD). Chlamydia is more prevalent among adolescents and young adults aged 14 to 24 years. Most infected people do not have any symptoms and therefore do not realize they have the infection and require treatment. Pregnant women who have a chlamydial infection can pass the disease to the infant during childbirth, and it is a leading cause of conjunctivitis (pink eye) and pneumonia in newborns. Untreated chlamydia can damage a woman's reproductive organs, possibly causing permanent and irreversible damage to the fallopian tubes and uterus, leading to infertility.

CDC Fact Sheet – Chlamydia, 2014
Division of STD Prevention
Centers for Disease Control and Prevention

1+ CHLAMYDIA SCREENING – 16 TO 24 YEARS OF AGE



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Data Source: HEDIS® Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care for Adults – General Health

The general health of adult patients is significantly impacted by their access to and receipt of adequate primary care assessments, preventive services and routine evaluations, which all contribute to improved health outcomes. The evaluation of developing risk factors as well as preventive health screenings can contribute greatly to a higher quality of life for individuals and lower health care costs for the community.

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

PRIMARY CARE FOR ADULTS – GENERAL HEALTH

Adults' Access to Preventive/ Ambulatory Health Services

DESCRIPTION

Each health benefit plan reports on multiple indicators under this measure. Three separate indicators include:

1. The percentage of adults aged 20 to 44 years in 2013 who had at least one outpatient visit, including an ambulatory or preventive care visit during the 2013 measurement year or the two years prior.

For this performance indicator, a higher percentage is better, which means that more adults 20 to 44 years of age did have at least one ambulatory or preventive care visit.

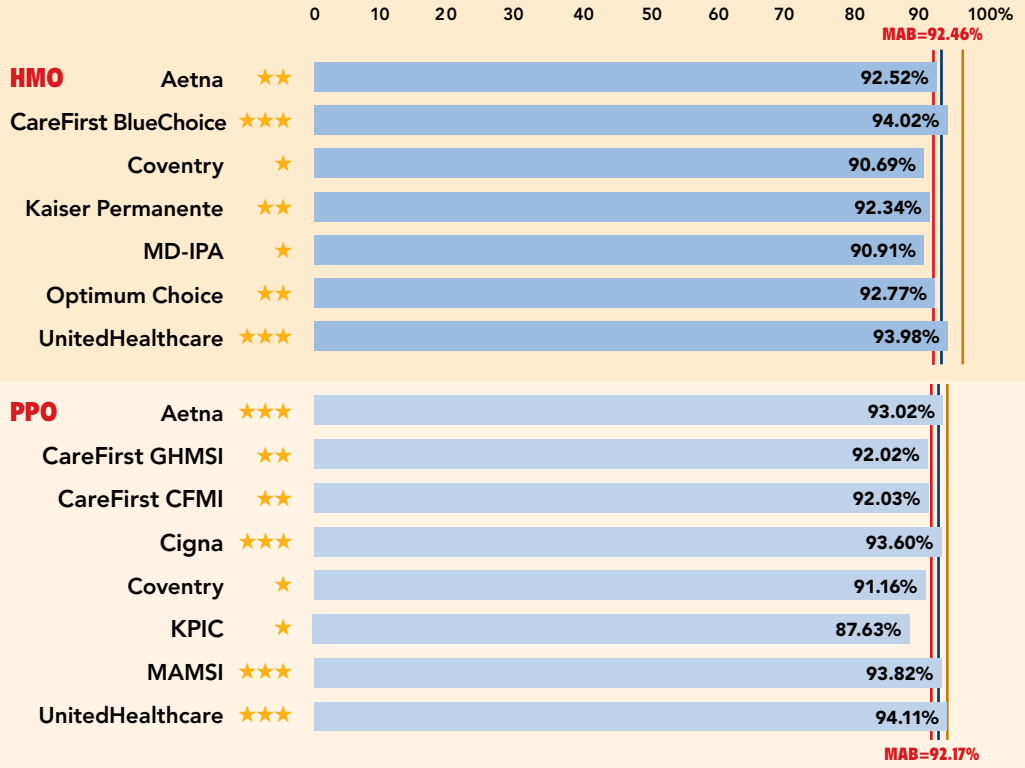
RATIONALE

Access to primary care providers such as pediatricians, family doctors, nurse practitioners, and other providers improves opportunities for appropriate use of prevention and wellness services and the proper screening for communicable diseases. Access to health services encompasses four areas of importance:

- Coverage – lack of adequate health insurance coverage makes it difficult for people to get the health care they need
- Services – in addition to primary care and preventive services, access to emergency medical services is a crucial link in the chain of care
- Timeliness – the ability to access care quickly after a need is recognized is associated with improved patient satisfaction and health outcomes
- Workforce – to improve the nation's health, it is important to increase the number of practicing primary care providers across all communities

Healthy People 2020
U.S. Department of Health and Human Services

OUTPATIENT VISIT – 20 TO 44 YEARS OF AGE



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BENCHMARKS

MAB (MARYLAND AVERAGE)
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NTP (NATIONAL TOP PERFORMERS)

Data Source: HEDIS® Submission or Health Benefit Plan Records

Adults' Access to Preventive/ Ambulatory Health Services continued

DESCRIPTION

2. The percentage of adults aged 45 to 64 years in 2013 who had at least one outpatient visit, including an ambulatory or preventive care visit during the 2013 measurement year or the two years prior.

For this performance indicator, a higher percentage is better, which means that more adults 45 to 64 years of age did have at least one ambulatory or preventive care visit.

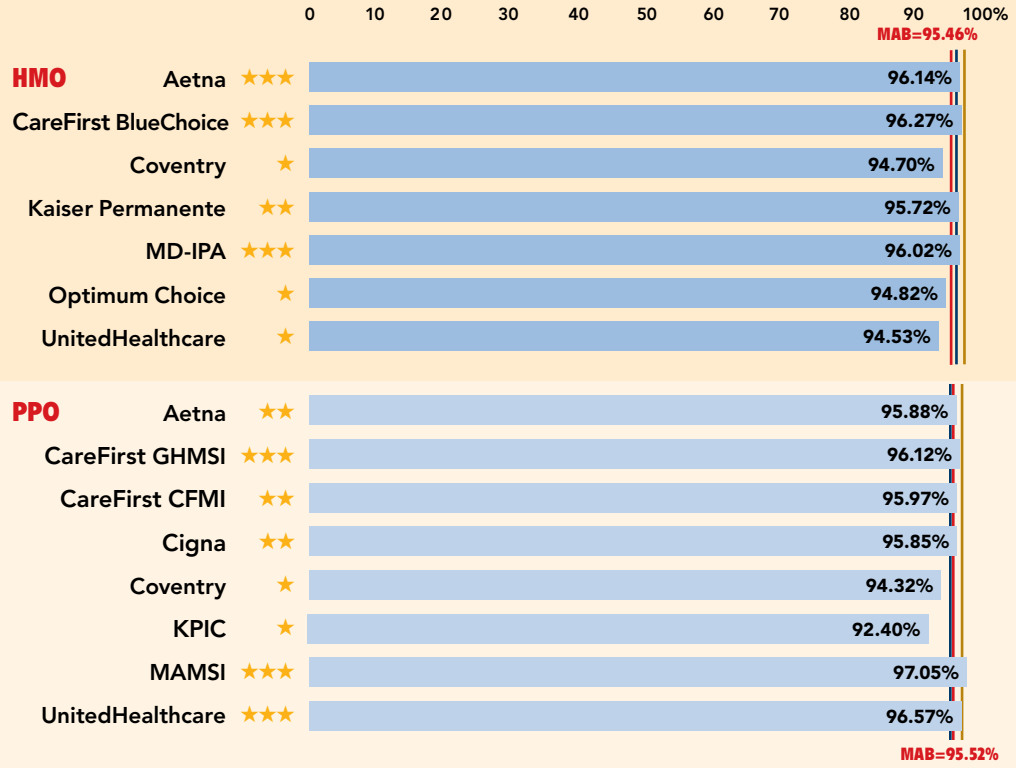
RATIONALE

Access to primary care providers such as pediatricians, family doctors, nurse practitioners, and other providers improves opportunities for appropriate use of prevention and wellness services and the proper screening for communicable diseases. Access to health services encompasses four areas of importance:

- Coverage – lack of adequate health insurance coverage makes it difficult for people to get the health care they need
- Services – in addition to primary care and preventive services, access to emergency medical services is a crucial link in the chain of care
- Timeliness – the ability to access care quickly after a need is recognized is associated with improved patient satisfaction and health outcomes
- Workforce – to improve the nation's health, it is important to increase the number of practicing primary care providers across all communities

Healthy People 2020
U.S. Department of Health and Human Services

OUTPATIENT VISIT – 45 TO 64 YEARS OF AGE



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BENCHMARKS

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Data Source: HEDIS® Submission or Health Benefit Plan Records

Adults' Access to Preventive/ Ambulatory Health Services continued

DESCRIPTION

3. The percentage of adults aged 65 years and older in 2013 who had at least one outpatient visit, including an ambulatory or preventive care visit during the 2013 measurement year or the two years prior.

For this performance indicator, a higher percentage is better, which means that more seniors did have at least one ambulatory or preventive care visit.

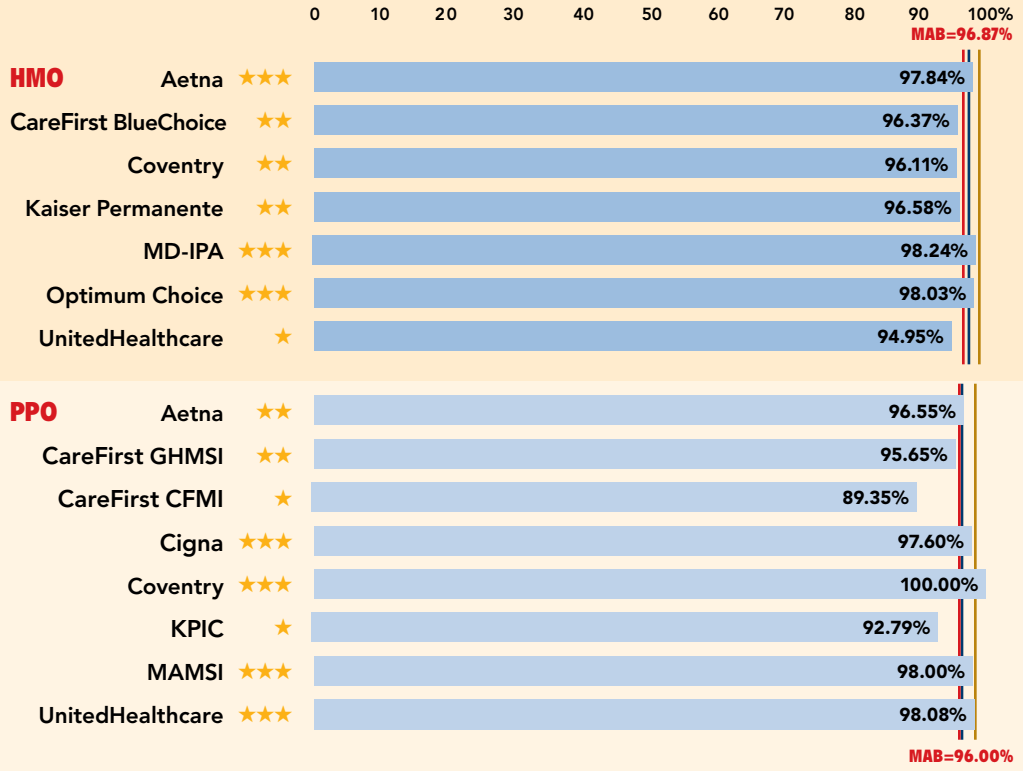
RATIONALE

Access to primary care providers such as pediatricians, family doctors, nurse practitioners, and other providers improves opportunities for appropriate use of prevention and wellness services and the proper screening for communicable diseases. Access to health services encompasses four areas of importance:

- Coverage – lack of adequate health insurance coverage makes it difficult for people to get the health care they need
- Services – in addition to primary care and preventive services, access to emergency medical services is a crucial link in the chain of care
- Timeliness – the ability to access care quickly after a need is recognized is associated with improved patient satisfaction and health outcomes
- Workforce – to improve the nation's health, it is important to increase the number of practicing primary care providers across all communities

Healthy People 2020
U.S. Department of Health and Human Services

OUTPATIENT VISIT – 65+ YEARS OF AGE



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BENCHMARKS

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Data Source: HEDIS® Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

PRIMARY CARE FOR ADULTS – GENERAL HEALTH

Adult Body Mass Index (BMI) Assessment

DESCRIPTION

The percentage of adults aged 18 to 74 years in 2013 who had an outpatient visit and whose weight was assessed and body mass index (BMI) was documented during the 2013 measurement year or the prior year. Because BMI norms vary with age and gender, this measure evaluates whether BMI percentile is assessed for a group aged between 18 to 74 years, rather than an absolute BMI value.

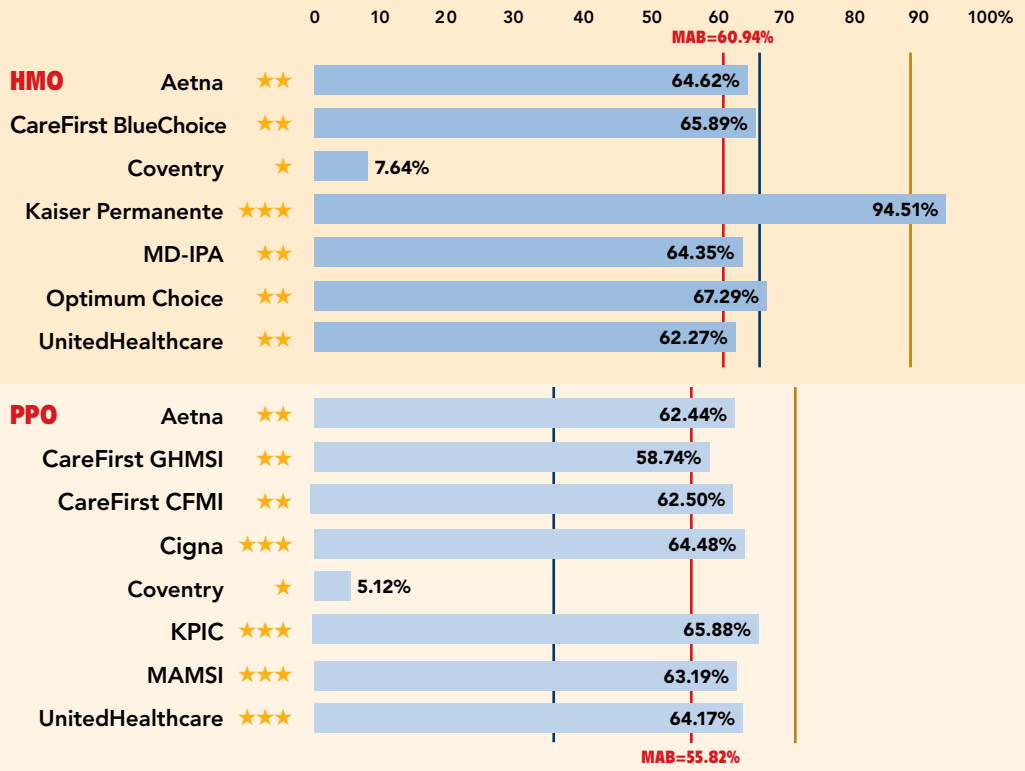
For this measure, a higher percentage is better, which means that more adults 18 to 74 years of age did have an outpatient visit, which included having their BMI calculated and documented.

RATIONALE

Obesity is the second leading cause of preventable death in the United States. Obesity often increases the severity of other illnesses and also increases the risk of developing additional conditions such as diabetes, coronary heart disease and cancer. Body mass index (BMI) is a number calculated from a person's weight and height. BMI provides a reliable way to screen for weight categories that may lead to health problems.

National Center for Chronic Disease Prevention and Health Promotion, 2014
Centers for Disease Control and Prevention

BODY MASS INDEX – 18 TO 74 YEARS OF AGE



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BENCHMARKS

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NTP (NATIONAL TOP PERFORMERS)

Data Source: HEDIS® Submission or Health Benefit Plan Records

Colorectal Cancer Screening

DESCRIPTION

The percentage of adults aged 50 to 75 years in 2013 who had at least one appropriate type of screening for colorectal cancer during the appropriate time based on the screening method used:

- Fecal occult blood test during the 2013 measurement year
- Flexible sigmoidoscopy test during 2013 or four years prior
- Colonoscopy test during 2013 or nine years prior

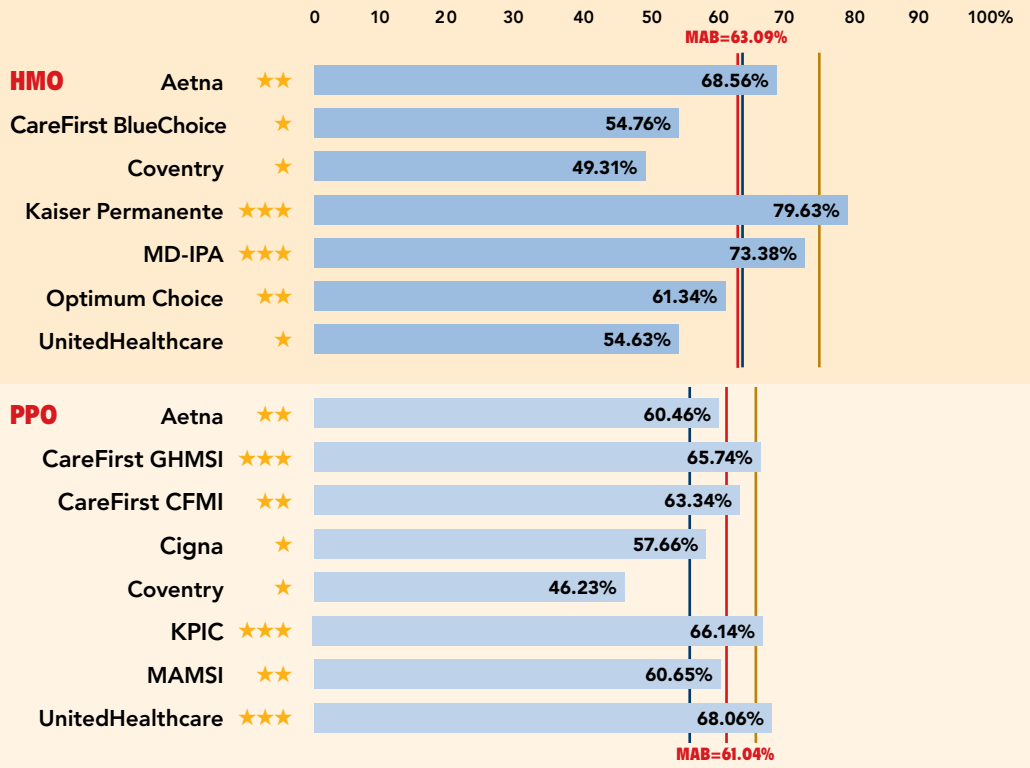
For this measure, a higher percentage is better, which means that more adults 50 to 75 years of age did get screened for colorectal cancer.

RATIONALE

Colorectal cancer is the second leading cause of cancer death in the United States. Unlike other screening tests that only detect disease, some methods of colorectal cancer screening can detect premalignant polyps and guide their removal which, in theory, can prevent the cancer from developing. Colorectal cancer screening may also lower mortality by allowing detection of cancer at earlier stages, when treatment is more effective. Most experts generally recommend colorectal cancer screening tests such as a high-sensitivity fecal occult blood test (FBOT), sigmoidoscopy and standard or optical colonoscopy.

National Cancer Institute, 2014
National Institutes of Health

+1 COLORECTAL CANCER SCREENING – 50 TO 75 YEARS OF AGE



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IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care for Adults – Respiratory Conditions

Primary care medicine is vitally important in the diagnosis and treatment of adults with respiratory conditions such as acute bronchitis, chronic obstructive pulmonary disease (COPD) and asthma. Through proper testing, medical treatment and education, patients continue to learn and become more effective participants in the management of their respiratory conditions.

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

DESCRIPTION

The percentage of adults aged 18 to 64 years of age in 2013 with a diagnosis of acute bronchitis who were appropriately not given an antibiotic prescription during the treatment period between January 1st and December 24th of the 2013 measurement year.

For this measure, a higher percentage is better, which means that more adults 18 to 64 years of age with acute bronchitis were appropriately treated and not given an antibiotic prescription as part of their treatment.

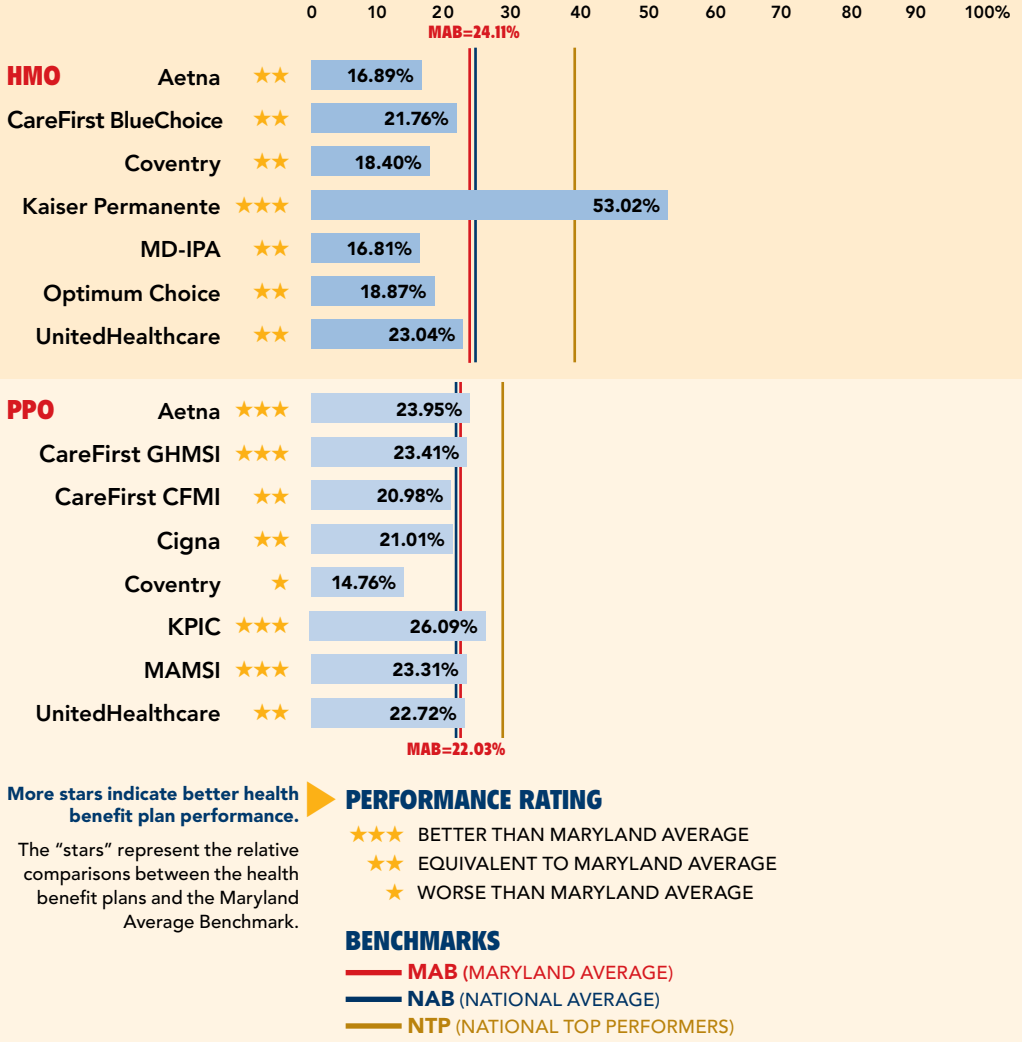
RATIONALE

"Acute bronchitis, or chest cold, is a condition that occurs when the bronchial tubes in the lungs become inflamed." Since acute bronchitis is most often caused by a virus, taking antibiotics will not make it better.

Inappropriate antibiotic treatment of adults with acute bronchitis is of clinical concern, especially since misuse and overuse of antibiotics leads to antibiotic drug resistance. Acute bronchitis can be prevented by quitting smoking and avoiding second hand smoke, good hand hygiene, and keeping up-to-date with recommended immunizations.

National Center for Immunization and Respiratory Diseases, 2013 Centers for Disease Control and Prevention

NOT GIVEN ANTIBIOTICS – 18 TO 64 YEARS OF AGE



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BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: HEDIS® Submission or Health Benefit Plan Records

Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease

DESCRIPTION

The percentage of adults aged 40 years or older in 2013 with a new diagnosis of Chronic Obstructive Pulmonary Disease (COPD) or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis during the 2013 measurement year.

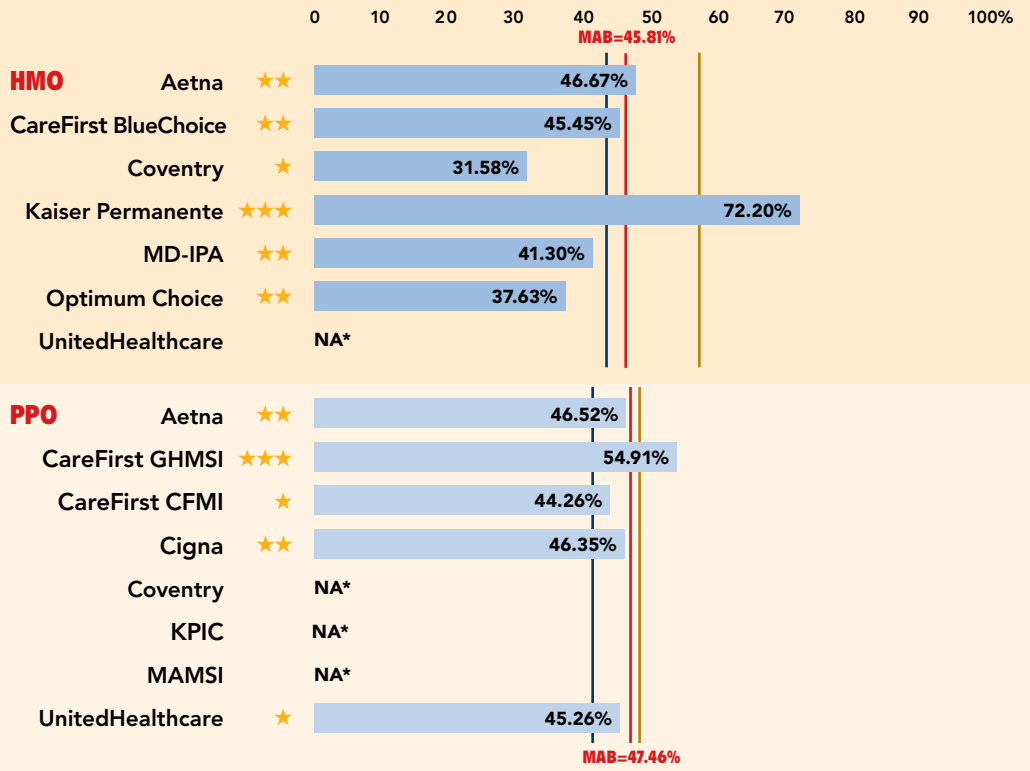
For this measure, a higher percentage is better, which means that more adults 40 years of age and over with COPD did get the best diagnostic test for COPD, a lung function test called spirometry.

RATIONALE

Chronic Obstructive Pulmonary Disease (COPD) refers to a group of diseases that cause airflow blockage and breathing problems. It includes chronic bronchitis, emphysema and in some cases, asthma. In the United States, tobacco smoke is a key factor in the development and progression of COPD. Spirometry is a simple test that measures the amount of air a person can breathe out and the amount of time it takes to do so. Both symptomatic and asymptomatic patients suspected of COPD should have spirometry testing performed to establish airway limitation and severity. Although several scientific guidelines and specialty societies recommend use of spirometry testing to confirm COPD diagnosis and determine severity of airflow limitation, spirometry tests are largely underutilized.

National Center for Chronic Disease Prevention and Health Promotion, 2013
Centers for Disease Control and Prevention

SPIROMETRY TEST – 40+ YEARS OF AGE



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BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

NA* Insufficient eligible members (fewer than 30) to calculate rate

Data Source: HEDIS® Submission or Health Benefit Plan Records

Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease Exacerbation

DESCRIPTION

Each health benefit plan reports on multiple indicators under this measure. Two separate indicators include:

1. The percentage of adults aged 40 years and over in 2013 who had an acute inpatient discharge or emergency department encounter for a Chronic Obstructive Pulmonary Disease (COPD) exacerbation on or between January 1st and November 30th of the 2013 measurement year, and who were given a prescription for a systemic corticosteroid within 14 days of the COPD event.

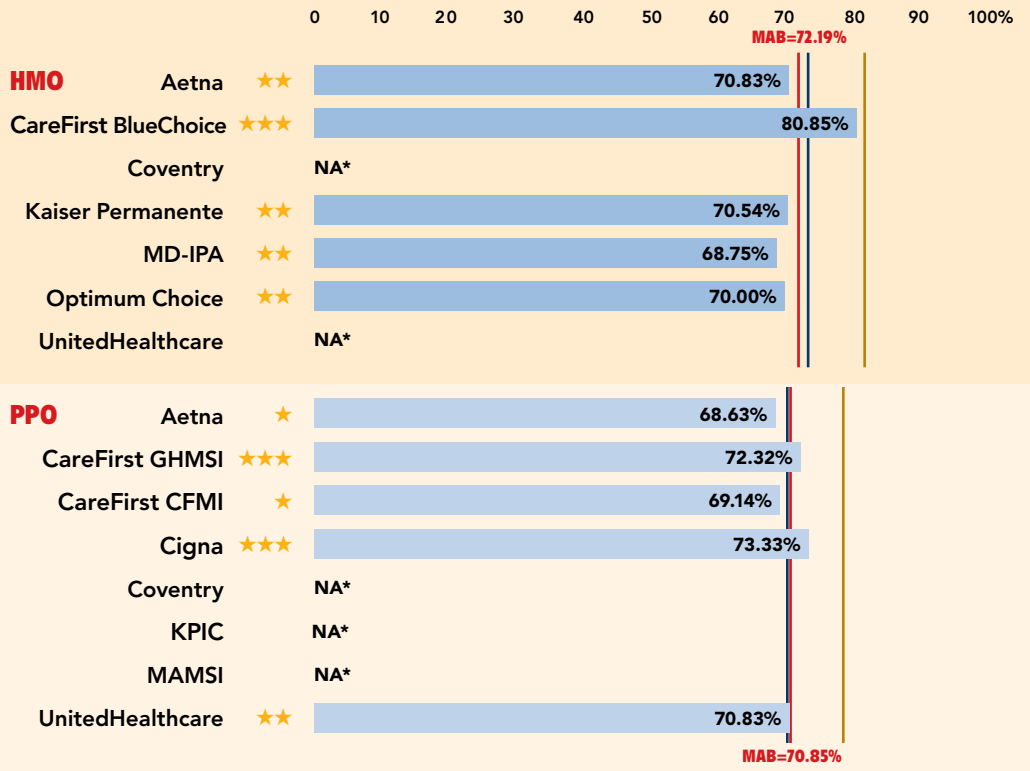
For this performance indicator, a higher percentage is better, which means that more adults 40 years of age and older did get a timely prescription for a systemic corticosteroid.

RATIONALE

Most people with Chronic Obstructive Pulmonary Disease (COPD) have both emphysema and chronic bronchitis. Medications used in COPD treatment include short or long-acting bronchodilators that relax the muscles around the airways, helping to open the airways and making it easier to breathe. Oral or inhaled corticosteroids are also used to prevent COPD flare-ups.

National Heart, Lung, and Blood Institute
National Institutes of Health

SYSTEMIC CORTICOSTEROID WITHIN 14 DAYS – 40+ YEARS OF AGE



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Data Source: HEDIS® Submission or Health Benefit Plan Records

Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease Exacerbation
continued

DESCRIPTION

2. The percentage of adults aged 40 years and over in 2013 who had an acute inpatient discharge or emergency department encounter for a Chronic Obstructive Pulmonary Disease (COPD) exacerbation on or between January 1st and November 30th of the 2013 measurement year, and who were given a prescription for a bronchodilator within 30 days of the COPD event.

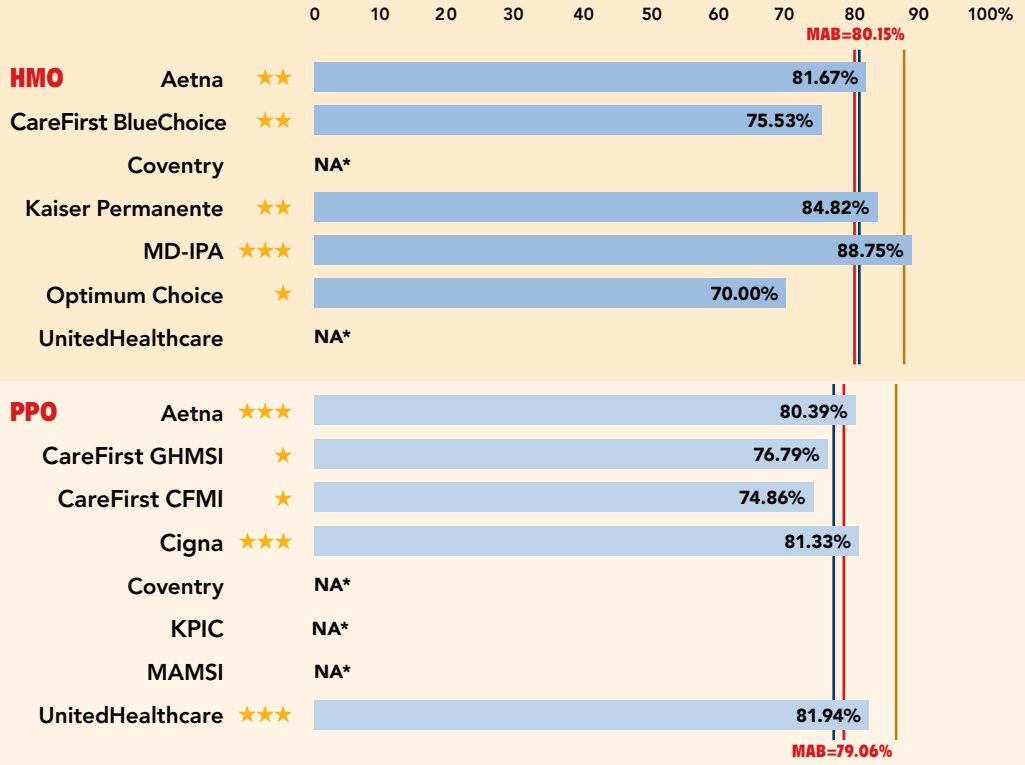
For this performance indicator, a higher percentage is better, which means that more adults 40 years of age and over did get a timely prescription for a bronchodilator.

RATIONALE

Most people with Chronic Obstructive Pulmonary Disease (COPD) have both emphysema and chronic bronchitis. Medications used in COPD treatment include short or long-acting bronchodilators that relax the muscles around the airways, helping to open the airways and making it easier to breathe. Oral or inhaled corticosteroids are also used to prevent COPD flare-ups.

National Heart, Lung, and Blood Institute
National Institutes of Health

BRONCHODILATOR WITHIN 30 DAYS – 40+ YEARS OF AGE



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IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

PRIMARY CARE FOR ADULTS – RESPIRATORY CONDITIONS

Use of Appropriate Medications for Adults with Asthma

DESCRIPTION

Each health benefit plan reports on multiple indicators under this measure. Two separate indicators include:

1. The percentage of adults aged 19 to 50 years in 2013 who were identified as having persistent asthma and who were appropriately prescribed asthma controller or reliever/rescue medication during the 2013 measurement year.

For this performance indicator, a higher percentage is better, which means that more adults 19 to 50 years of age with asthma were appropriately prescribed asthma medications.

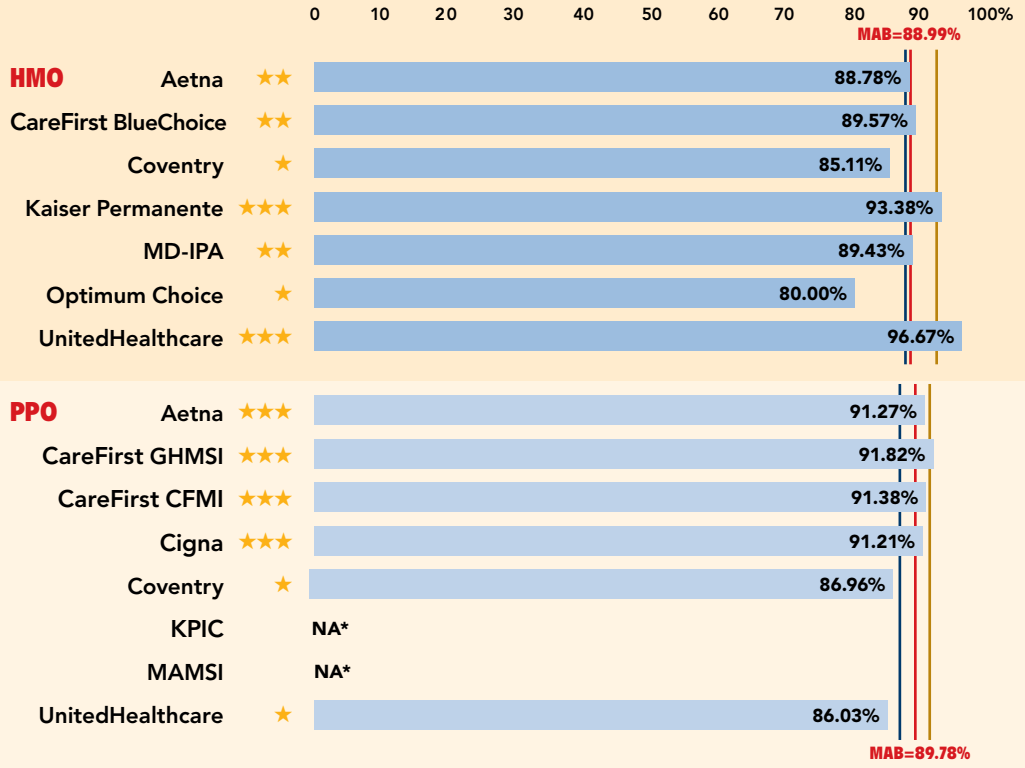
NOTE: Please find children 5 to 11 and 12 to 18 years of age in the Child Respiratory Conditions section.

RATIONALE

Asthma is one of the nation's most costly and widespread diseases, affecting children and adults alike. Approximately 19 million non-institutionalized adults have been diagnosed with asthma and each year more than 3,000 people in the United States die of it. Many asthma-related hospitalizations, emergency room visits and missed work and school days can be avoided if patients have appropriate medications and medical management. Appropriate medications help reduce underlying airway inflammation and relieve or prevent airway narrowing.

National Center for Health Statistics, 2011
Centers for Disease Control and Prevention

APPROPRIATE ASTHMA MEDICATIONS – 19 TO 50 YEARS OF AGE



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BENCHMARKS

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NTP (NATIONAL TOP PERFORMERS)

NA* Insufficient eligible members (fewer than 30) to calculate rate

Data Source: HEDIS® Submission or Health Benefit Plan Records

Use of Appropriate Medications for Adults with Asthma continued

DESCRIPTION

2. The percentage of adults aged 51 to 64 years in 2013 who were identified as having persistent asthma and who were appropriately prescribed asthma controller or reliever/rescue medication during the 2013 measurement year.

For this performance indicator, a higher percentage is better, which means that more adults 51 to 64 years of age with asthma were appropriately prescribed asthma medications.

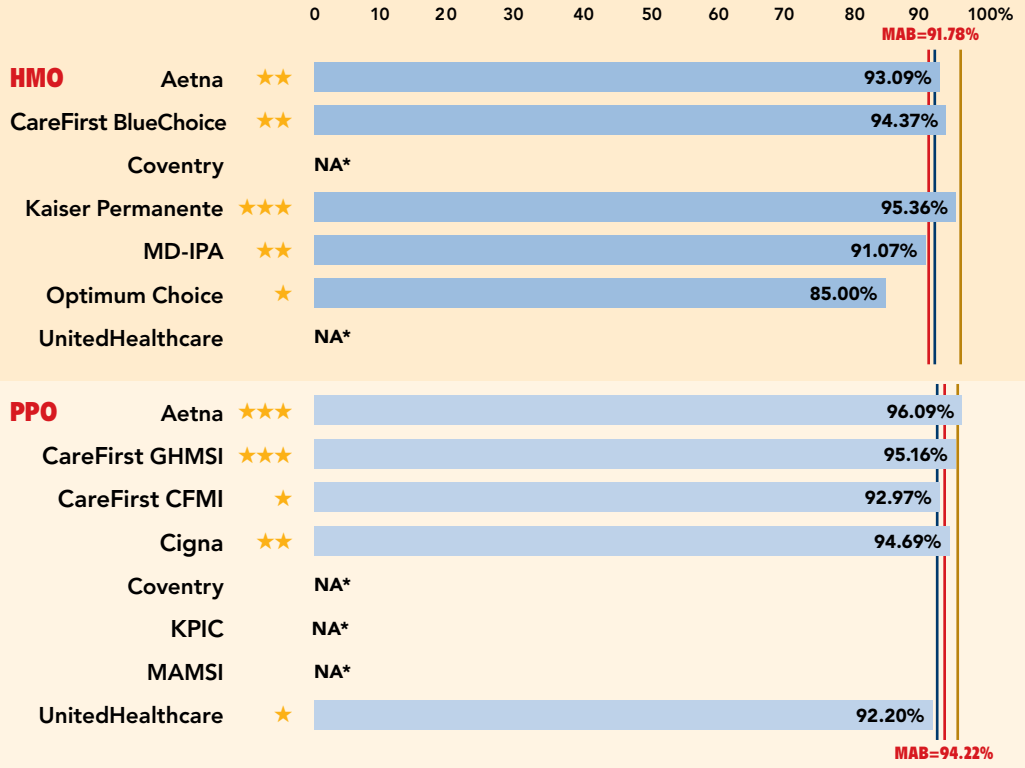
NOTE: Please find children 5 to 11 and 12 to 18 years of age in the Child Respiratory Conditions section.

RATIONALE

Asthma is one of the nation's most costly and widespread diseases, affecting children and adults alike. Approximately 19 million non-institutionalized adults have been diagnosed with asthma and each year more than 3,000 people in the United States die of it. Many asthma-related hospitalizations, emergency room visits and missed work and school days can be avoided if patients have appropriate medications and medical management. Appropriate medications help reduce underlying airway inflammation and relieve or prevent airway narrowing.

National Center for Health Statistics, 2011
Centers for Disease Control and Prevention

APPROPRIATE ASTHMA MEDICATIONS – 51 TO 64 YEARS OF AGE



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IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

PRIMARY CARE FOR ADULTS – RESPIRATORY CONDITIONS

Asthma Medication Ratio

DESCRIPTION

Each health benefit plan reports on multiple indicators under this measure. Two separate indicators include:

1. The percentage of adults aged 19 to 50 years in 2013 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the 2013 measurement year.

For this performance indicator, a higher percentage is better, which means that more adults 19 to 50 years of age with asthma were prescribed asthma controller medications at least as often as reliever/rescue medications, thereby demonstrating that asthma is being well controlled with fewer asthmatic emergencies that require reliever/rescue medications.

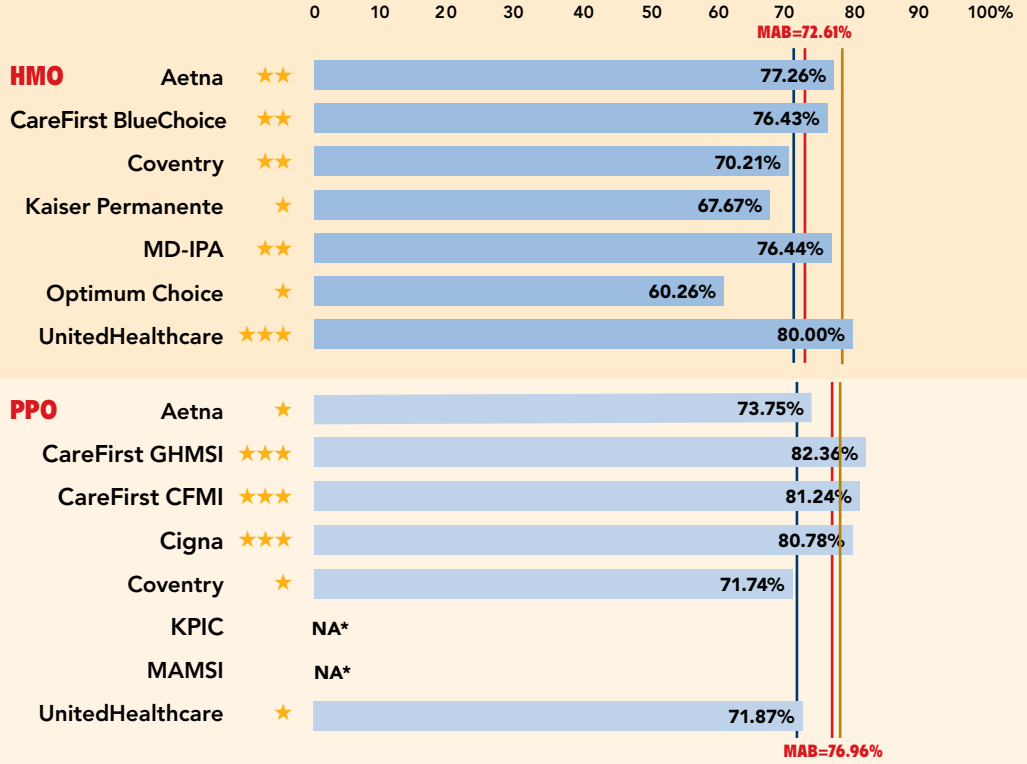
NOTE: Please find children 5 to 11 and 12 to 18 years of age in the Child Respiratory Conditions section.

RATIONALE

Asthma is one of the nation's most costly and widespread diseases, affecting children and adults alike. Approximately 19 million non-institutionalized adults have been diagnosed with asthma and each year more than 3,000 people in the United States die of it. Many asthma-related hospitalizations, emergency room visits and missed work and school days can be avoided if patients have appropriate medications and medical management. Appropriate medications help reduce underlying airway inflammation and relieve or prevent airway narrowing.

National Center for Health Statistics, 2011
Centers for Disease Control and Prevention

ASTHMA CONTROLLER MEDICATION RATIO ≥50% – 19 TO 50 YEARS OF AGE



More stars indicate better health benefit plan performance.

The "stars" represent the relative comparisons between the health benefit plans and the Maryland Average Benchmark.

PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

NA* Insufficient eligible members (fewer than 30) to calculate rate

Data Source: HEDIS® Submission or Health Benefit Plan Records

Asthma Medication Ratio continued

DESCRIPTION

2. The percentage of adults aged 51 to 64 years in 2013 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the 2013 measurement year.

For this performance indicator, a higher percentage is better, which means that more adults 51 to 64 years of age with asthma were prescribed asthma controller medications at least as often as reliever/rescue medications, thereby demonstrating that asthma is being well controlled with fewer asthmatic emergencies that require reliever/rescue medications.

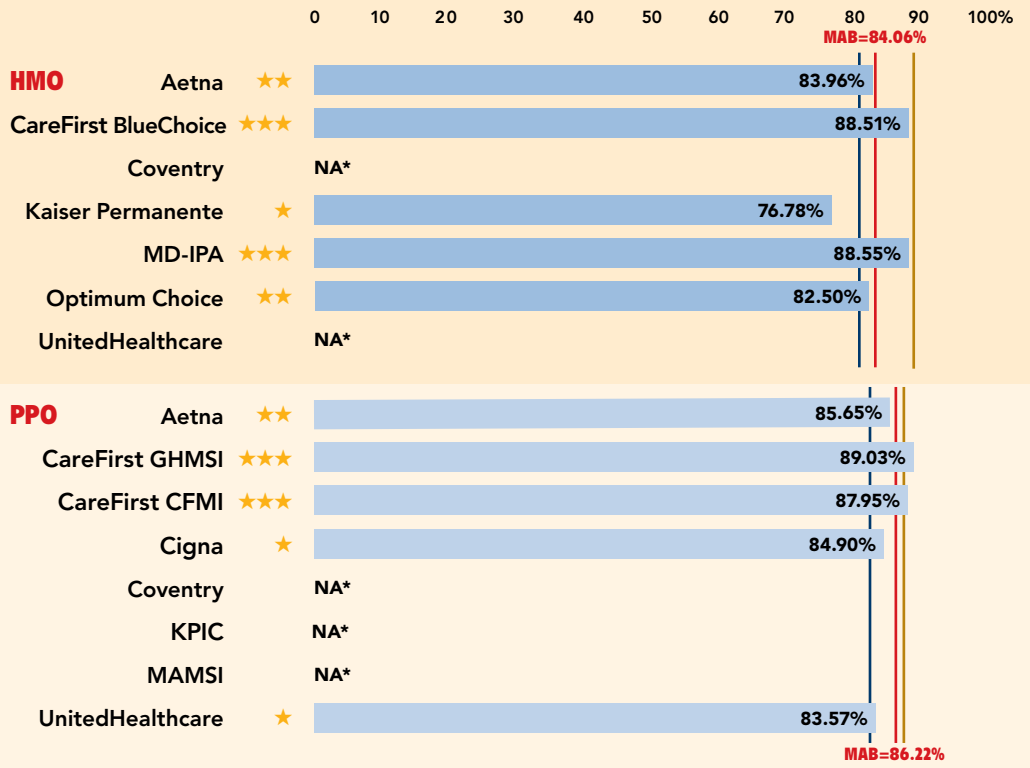
NOTE: Please find children 5 to 11 and 12 to 18 years of age in the Child Respiratory Conditions section.

RATIONALE

Asthma is one of the nation's most costly and widespread diseases, affecting children and adults alike. Approximately 19 million non-institutionalized adults have been diagnosed with asthma and each year more than 3,000 people in the United States die of it. Many asthma-related hospitalizations, emergency room visits and missed work and school days can be avoided if patients have appropriate medications and medical management. Appropriate medications help reduce underlying airway inflammation and relieve or prevent airway narrowing.

National Center for Health Statistics, 2011
Centers for Disease Control and Prevention

ASTHMA CONTROLLER MEDICATION RATIO ≥50% – 51 TO 64 YEARS OF AGE



More stars indicate better health benefit plan performance.

The "stars" represent the relative comparisons between the health benefit plans and the Maryland Average Benchmark.

PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

NA* Insufficient eligible members (fewer than 30) to calculate rate

Data Source: HEDIS® Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

PRIMARY CARE FOR ADULTS – RESPIRATORY CONDITIONS

Medication Management for Adults with Asthma

DESCRIPTION

Each health benefit plan reports on multiple indicators under this measure. Four separate indicators include:

1. The percentage of adults aged 19 to 50 years in 2013 who were identified as having persistent asthma, were given a prescription for an appropriate medication including an asthma controller or reliever/rescue medication, and who remained on that medication for at least 50% of the remaining days in 2013.

For this performance indicator, a higher percentage is better, which means that more adults 19 to 50 years of age with asthma remained compliant on their asthma medication for at least 50% of the treatment period.

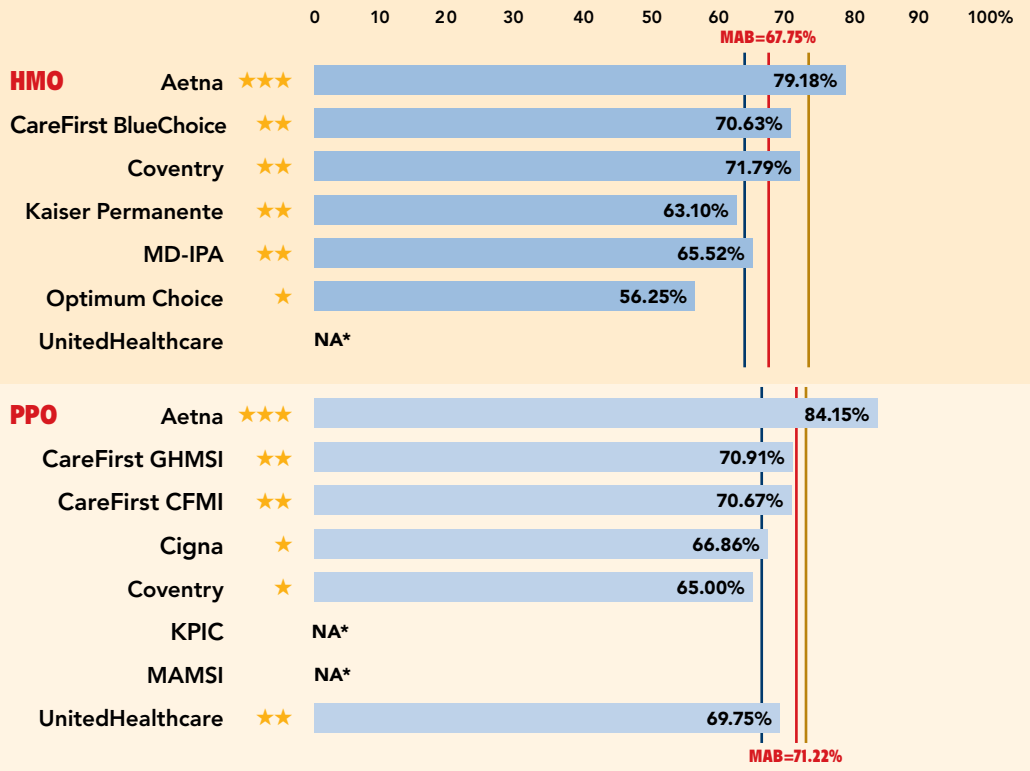
NOTE: Please find children 5 to 11 and 12 to 18 years of age in the Child Respiratory Conditions section.

RATIONALE

Asthma is one of the nation's most costly and widespread diseases, affecting children and adults alike. Approximately 19 million non-institutionalized adults have been diagnosed with asthma and each year more than 3,000 people in the United States die of it. Many asthma-related hospitalizations, emergency room visits and missed work and school days can be avoided if patients have appropriate medications and medical management. Appropriate medications help reduce underlying airway inflammation and relieve or prevent airway narrowing.

National Center for Health Statistics, 2011
Centers for Disease Control and Prevention

50% TREATMENT COMPLIANCE – 19 TO 50 YEARS OF AGE



More stars indicate better health benefit plan performance.

The "stars" represent the relative comparisons between the health benefit plans and the Maryland Average Benchmark.

PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

NA* Insufficient eligible members (fewer than 30) to calculate rate

Data Source: HEDIS® Submission or Health Benefit Plan Records

Medication Management for Adults with Asthma
continued

DESCRIPTION

2. The percentage of adults aged 51 to 64 years in 2013 who were identified as having persistent asthma, were given a prescription for an appropriate medication including an asthma controller or reliever/rescue medication, and who remained on that medication for at least 50% of the remaining days in 2013.

For this performance indicator, a higher percentage is better, which means that more adults 51 to 64 years of age with asthma remained compliant on their asthma medication for at least 50% of the treatment period.

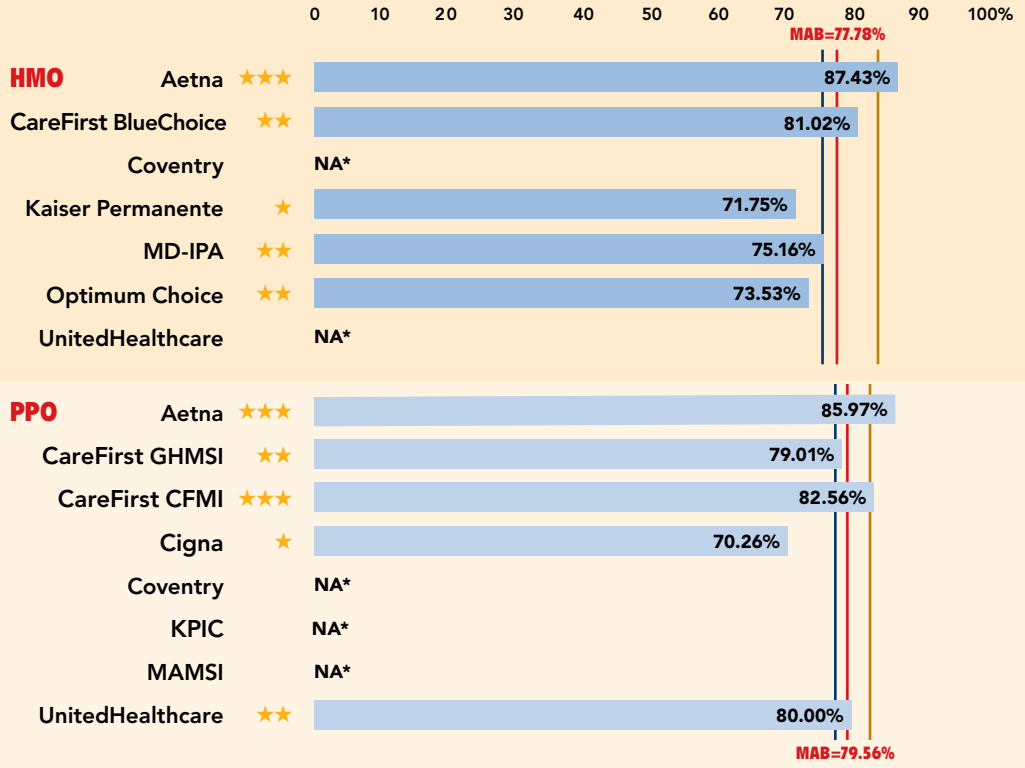
NOTE: Please find children 5 to 11 and 12 to 18 years of age in the Child Respiratory Conditions section.

RATIONALE

Asthma is one of the nation's most costly and widespread diseases, affecting children and adults alike. Approximately 19 million non-institutionalized adults have been diagnosed with asthma and each year more than 3,000 people in the United States die of it. Many asthma-related hospitalizations, emergency room visits and missed work and school days can be avoided if patients have appropriate medications and medical management. Appropriate medications help reduce underlying airway inflammation and relieve or prevent airway narrowing.

National Center for Health Statistics, 2011
Centers for Disease Control and Prevention

50% TREATMENT COMPLIANCE – 51 TO 64 YEARS OF AGE



More stars indicate better health benefit plan performance.

The "stars" represent the relative comparisons between the health benefit plans and the Maryland Average Benchmark.

PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

NA* Insufficient eligible members (fewer than 30) to calculate rate

Data Source: HEDIS® Submission or Health Benefit Plan Records

Medication Management for Adults with Asthma
continued

DESCRIPTION

3. The percentage of adults aged 19 to 50 years in 2013 who were identified as having persistent asthma, were given a prescription for an appropriate medication including an asthma controller or reliever/rescue medication, and who remained on that medication for at least 75% of the remaining days in 2013.

For this performance indicator, a higher percentage is better, which means that more adults 19 to 50 years of age with asthma remained compliant on their asthma medication for at least 75% of the treatment period.

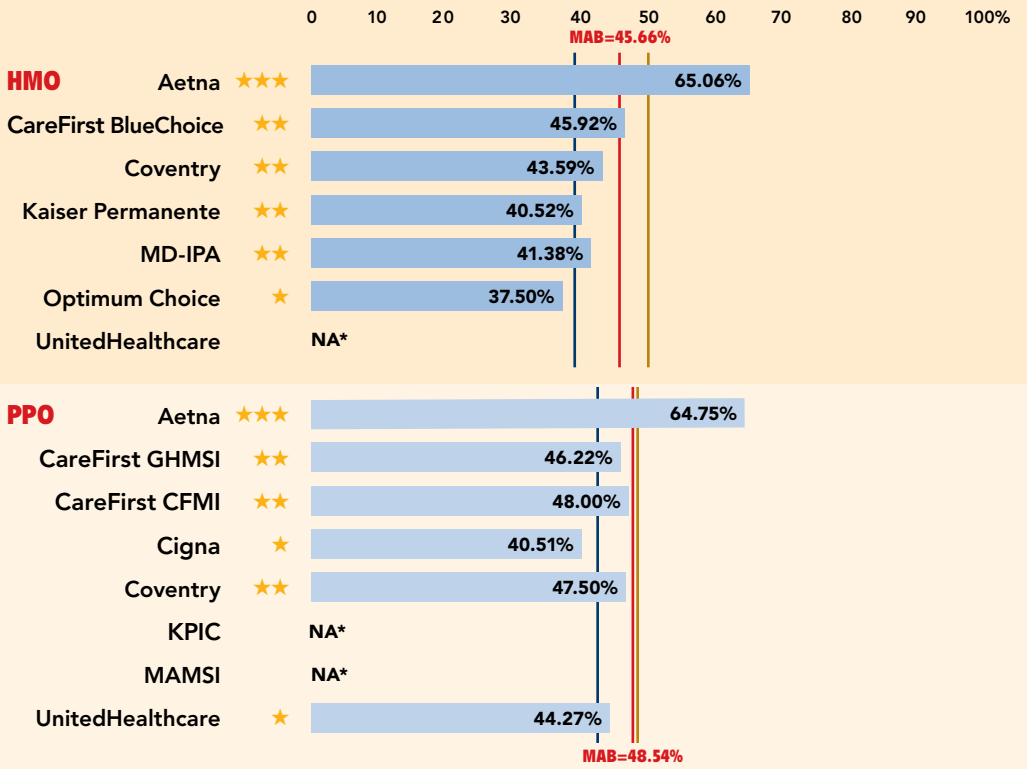
NOTE: Please find children 5 to 11 and 12 to 18 years of age in the Child Respiratory Conditions section.

RATIONALE

Asthma is one of the nation's most costly and widespread diseases, affecting children and adults alike. Approximately 19 million non-institutionalized adults have been diagnosed with asthma and each year more than 3,000 people in the United States die of it. Many asthma-related hospitalizations, emergency room visits and missed work and school days can be avoided if patients have appropriate medications and medical management. Appropriate medications help reduce underlying airway inflammation and relieve or prevent airway narrowing.

National Center for Health Statistics, 2011
Centers for Disease Control and Prevention

75% TREATMENT COMPLIANCE – 19 TO 50 YEARS OF AGE



More stars indicate better health benefit plan performance.

The "stars" represent the relative comparisons between the health benefit plans and the Maryland Average Benchmark.

PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

NA* Insufficient eligible members (fewer than 30) to calculate rate

Data Source: HEDIS® Submission or Health Benefit Plan Records

Medication Management for Adults with Asthma
continued

DESCRIPTION

4. The percentage of adults aged 51 to 64 years in 2013 who were identified as having persistent asthma, were given a prescription for an appropriate medication including an asthma controller or reliever/rescue medication, and who remained on that medication for at least 75% of the remaining days in 2013.

For this performance indicator, a higher percentage is better, which means that more adults 51 to 64 years of age with asthma remained compliant on their asthma medication for at least 75% of the treatment period.

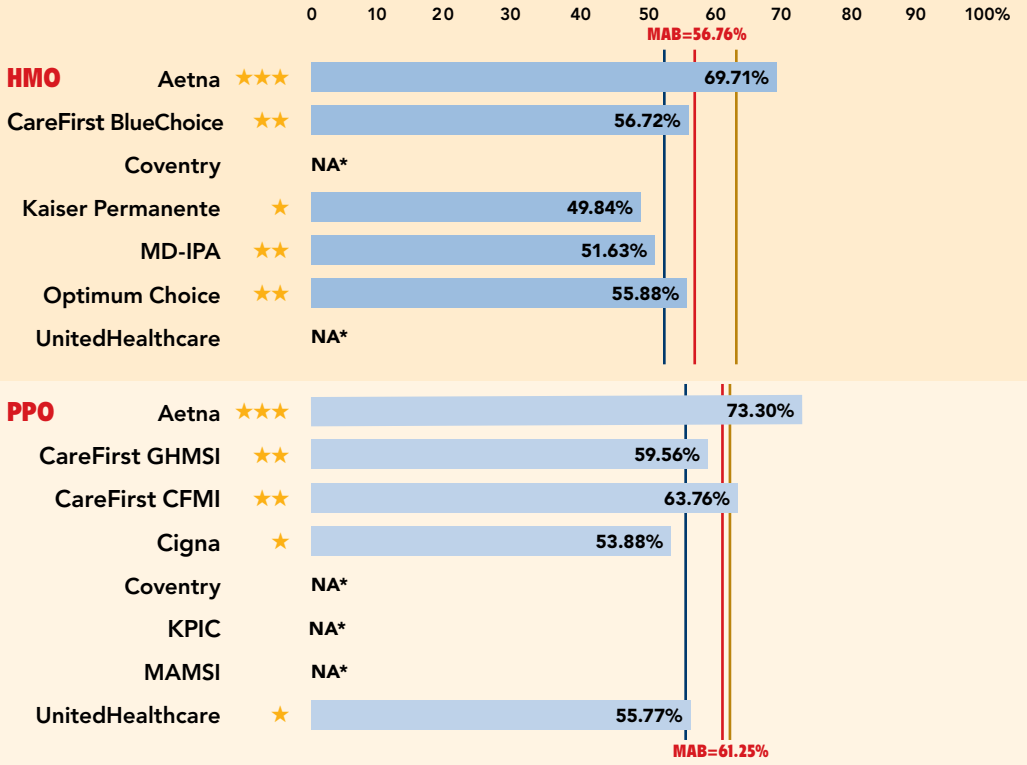
NOTE: Please find children 5 to 11 and 12 to 18 years of age in the Child Respiratory Conditions section.

RATIONALE

Asthma is one of the nation's most costly and widespread diseases, affecting children and adults alike. Approximately 19 million non-institutionalized adults have been diagnosed with asthma and each year more than 3,000 people in the United States die of it. Many asthma-related hospitalizations, emergency room visits and missed work and school days can be avoided if patients have appropriate medications and medical management. Appropriate medications help reduce underlying airway inflammation and relieve or prevent airway narrowing.

National Center for Health Statistics, 2011
Centers for Disease Control and Prevention

75% TREATMENT COMPLIANCE – 51 TO 64 YEARS OF AGE



More stars indicate better health benefit plan performance.

The "stars" represent the relative comparisons between the health benefit plans and the Maryland Average Benchmark.

PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

NA* Insufficient eligible members (fewer than 30) to calculate rate

Data Source: HEDIS® Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care for Adults – Cardiovascular Conditions and Diabetes

Many people with diabetes are at risk for developing cardiovascular disease, also referred to as heart and blood vessel disease. A comprehensive approach to care is therefore required, and consists of a strong program that targets prevention as well as treatment. Lifestyle changes such as diet, exercise, stress management and quitting smoking are key preventive health care efforts. Medications to control blood sugar, blood pressure and cholesterol levels, as well as other medications, therapies, monitoring, and testing are important health care treatment efforts that optimize health and wellness while controlling health care costs.

Cholesterol Management for Patients with Cardiovascular Conditions

DESCRIPTION

Each health benefit plan reports on multiple indicators under this measure. Two separate indicators include:

1. Low-Density Lipoprotein Cholesterol (LDL-C) Screening: The percentage of adults aged 18 to 75 years in 2013 who were discharged alive for a heart attack or acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous coronary interventions (PCI) commonly known as angioplasty or stent procedure, from January 1 through November 1 of the year prior to the measurement year (2012), or who had a diagnosis of ischemic vascular disease (IVD) during the 2013 measurement year and the prior year, who had a low-density lipoprotein cholesterol (LDL-C) screening.

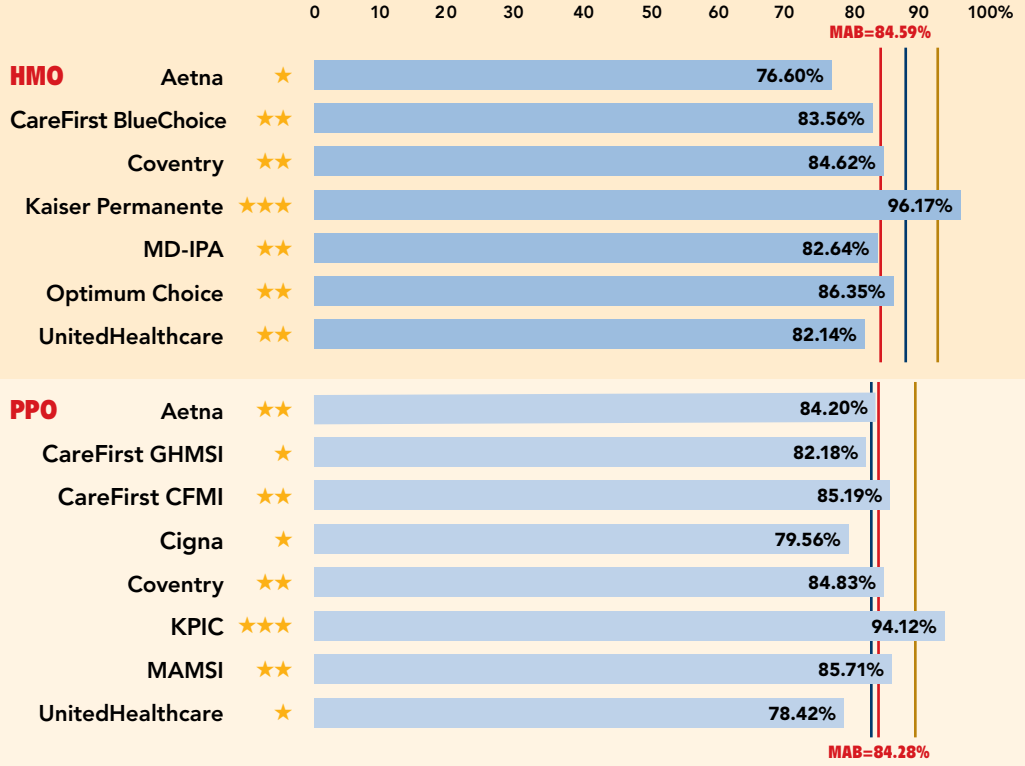
For this performance indicator, a higher percentage is better, which means that more adults 18 to 75 years of age, at increased risk for cardiovascular events, did get appropriate LDL cholesterol screening.

RATIONALE

Some cholesterol in the body is needed for good health, but too much can cause arteries to become blocked and result in heart disease. Screening tests often determine the levels of different types of cholesterol in the blood; however, the level of low-density lipoprotein (LDL) cholesterol, often called bad cholesterol, is a "key predictor of future disease." Lifestyle modification including quitting smoking, eating right and getting physically fit can reduce LDL cholesterol levels. Cholesterol-lowering medications such as statins and others can also help get cholesterol under good control (<100 mg/dL).

National Center for Chronic Disease Prevention and Health Promotion, 2013
Centers for Disease Control and Prevention

LDL CHOLESTEROL SCREENING (CARDIOVASCULAR) – 18 TO 75 YEARS OF AGE



More stars indicate better health benefit plan performance.

The "stars" represent the relative comparisons between the health benefit plans and the Maryland Average Benchmark.

PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: HEDIS® Submission or Health Benefit Plan Records

Cholesterol Management for Patients with Cardiovascular Conditions continued

DESCRIPTION

2. Low-Density Lipoprotein Cholesterol (LDL-C) Control: The percentage of adults aged 18 to 75 years in 2013 who were discharged alive for a heart attack or acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous coronary interventions (PCI) commonly known as angioplasty or stent procedure, from January 1 through November 1 of the year prior to the measurement year (2012), or who had a diagnosis of ischemic vascular disease (IVD) during the 2013 measurement year and the prior year, who had a cholesterol level less than 100 mg/dL on their LDL-C Screening.

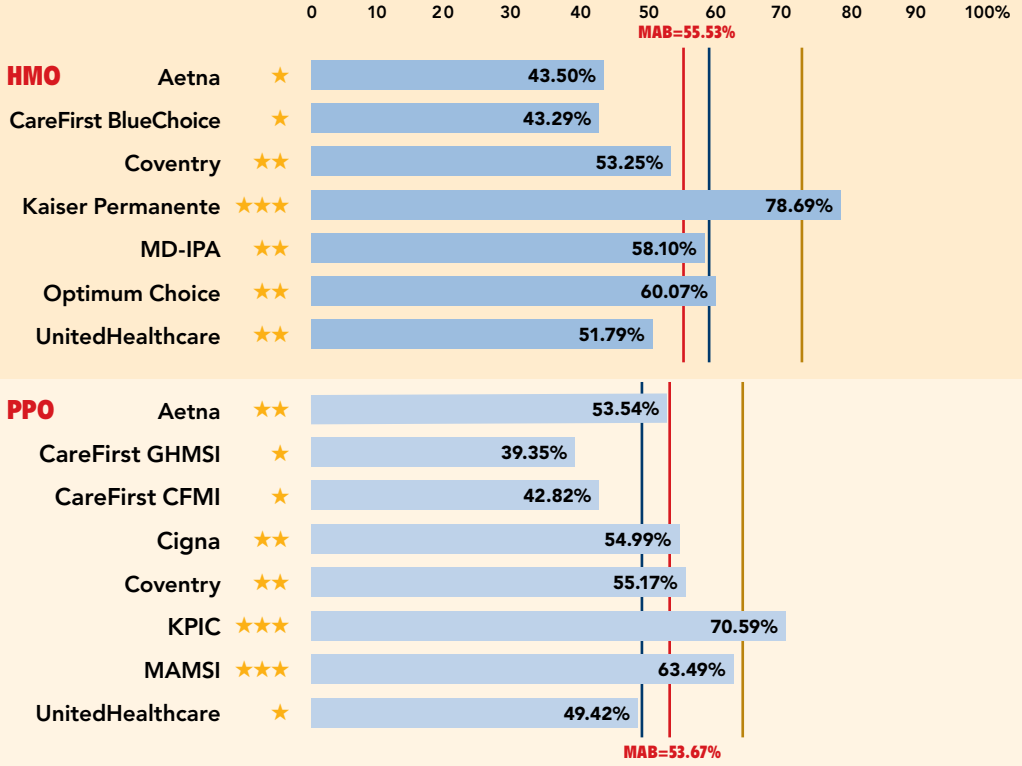
For this performance indicator, a higher percentage is better, which means that more adults 18 to 75 years of age, at increased risk for cardiovascular events, did achieve good cholesterol control with an LDL-C level below 100 mg/dL.

RATIONALE

Some cholesterol in the body is needed for good health, but too much can cause arteries to become blocked and result in heart disease. Screening tests often determine the levels of different types of cholesterol in the blood; however, the level of low-density lipoprotein (LDL) cholesterol, often called bad cholesterol, is a "key predictor of future disease." Lifestyle modification including quitting smoking, eating right and getting physically fit can reduce LDL cholesterol levels. Cholesterol-lowering medications such as statins and others can also help get cholesterol under good control (<100 mg/dL).

National Center for Chronic Disease Prevention and Health Promotion, 2013
Centers for Disease Control and Prevention

LDL CHOLESTEROL CONTROL <100 mg/dL (CARDIOVASCULAR) – 18 TO 75 YEARS OF AGE



More stars indicate better health benefit plan performance.

The "stars" represent the relative comparisons between the health benefit plans and the Maryland Average Benchmark.

PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: HEDIS® Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

PRIMARY CARE FOR ADULTS – CARDIOVASCULAR CONDITIONS AND DIABETES

Controlling High Blood Pressure

DESCRIPTION

The percentage of adults aged 18 to 85 years in 2013 who had a confirmed diagnosis of hypertension and through proper disease management, had blood pressure that was adequately controlled (<140/90 mm Hg) during the 2013 measurement year.

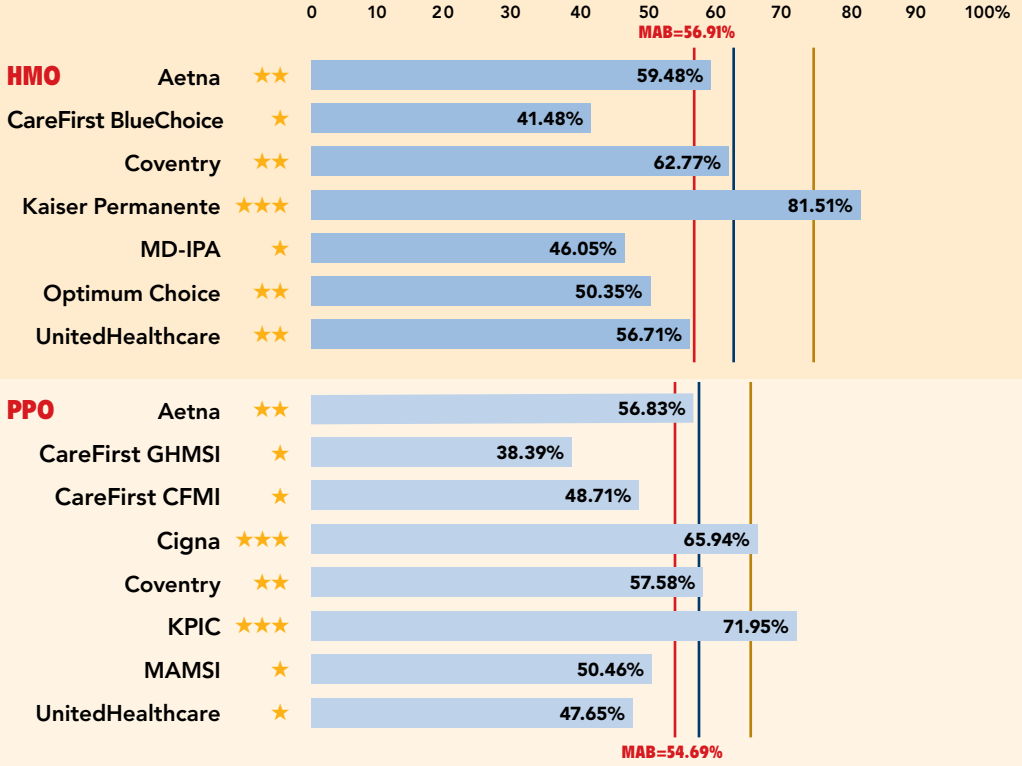
For this measure, a higher percentage is better, which means that more adults 18 to 85 years of age with hypertension did get adequate control of their blood pressure.

RATIONALE

"Blood pressure normally rises and falls throughout the day. But if it stays high for a long time, it can damage your heart and lead to [serious] health problems." Since there are no warning signs of the disease, it is important to have your blood pressure measured and make healthy choices that keep it in a healthy range. When a healthy lifestyle is not enough, one or more types of high blood pressure medication may be needed to achieve blood pressure control.

National Center for Chronic Disease Prevention and Health Promotion, 2013
Centers for Disease Control and Prevention

BLOOD PRESSURE CONTROL <140/90 mm Hg (CARDIOVASCULAR) – 18 TO 85 YEARS OF AGE



More stars indicate better health benefit plan performance.

The "stars" represent the relative comparisons between the health benefit plans and the Maryland Average Benchmark.

PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: HEDIS® Submission or Health Benefit Plan Records

Persistence of Beta-Blocker Treatment After a Heart Attack

DESCRIPTION

The percentage of adults aged 18 years and older in 2013 who were hospitalized and discharged alive from July 1 of the year prior to the measurement year (2012) through June 30 of the measurement year (2013) with a diagnosis of heart attack or acute myocardial infarction (AMI) and who received persistent beta-blocker treatment (a class of drugs commonly used to treat the heart) for six months after discharge.

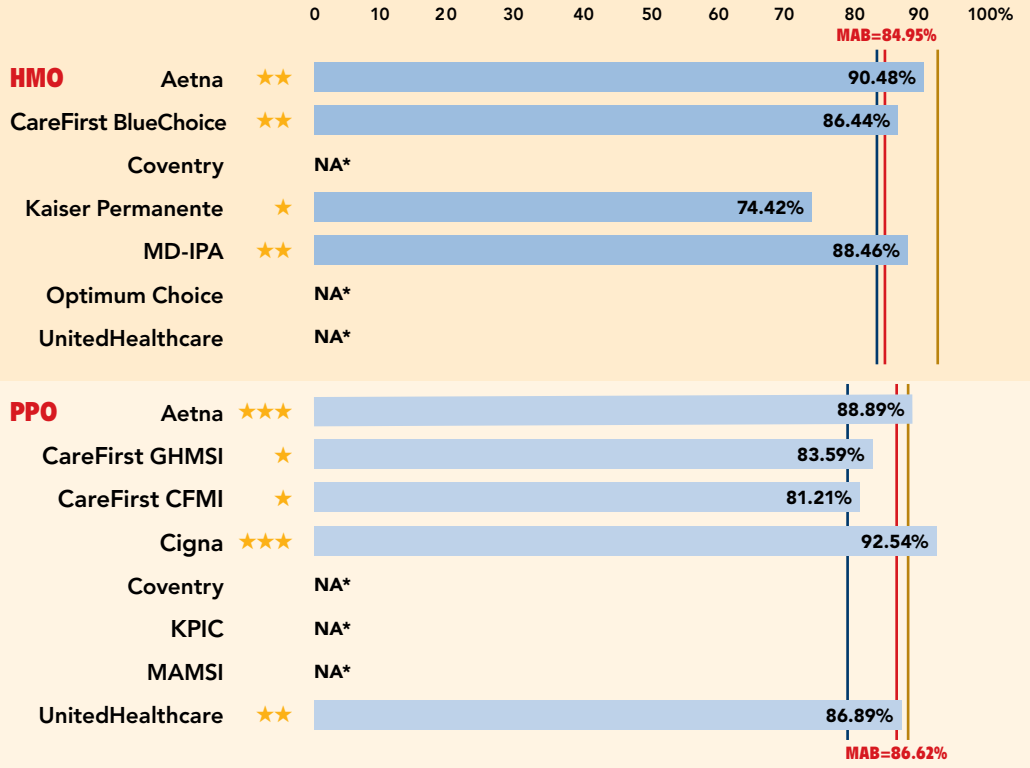
For this measure, a higher percentage is better, which means that more adults 18 years of age and over with a history of having a heart attack did get at least six months of beta-blocker treatment.

RATIONALE

Beta blockers are a class of medication that decreases the workload of the heart by slowing it down and thus reducing the chance of a repeat heart attack. Despite their benefits, underutilization of beta blockers persists. This underutilization may be attributed, in part, to some of the medication's side effects, including headache, depression and sexual dysfunction. After starting beta blocker therapy, it is important not to stop taking the medication suddenly because sudden withdrawal may worsen chest pain or even bring about another heart attack.

National Heart, Lung, and Blood Institute
National Institutes of Health

BETA-BLOCKER FOR 6 MONTHS AFTER DISCHARGE – 18+ YEARS OF AGE



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The "stars" represent the relative comparisons between the health benefit plans and the Maryland Average Benchmark.

PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

NA* Insufficient eligible members (fewer than 30) to calculate rate

Data Source: HEDIS® Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

PRIMARY CARE FOR ADULTS – CARDIOVASCULAR CONDITIONS AND DIABETES

Comprehensive Diabetes Care

DESCRIPTION

Each health benefit plan reports on multiple indicators under this measure. Ten separate indicators include:

1. Hemoglobin A1c (HbA1c) Testing: The percentage of adults aged 18 to 75 years in 2013 with diabetes (Type 1 and Type 2) who had HbA1c testing during the 2013 measurement year.

For this performance indicator, a higher percentage is better, which means that more diabetic adults 18 to 75 years of age did get appropriate HbA1c testing.

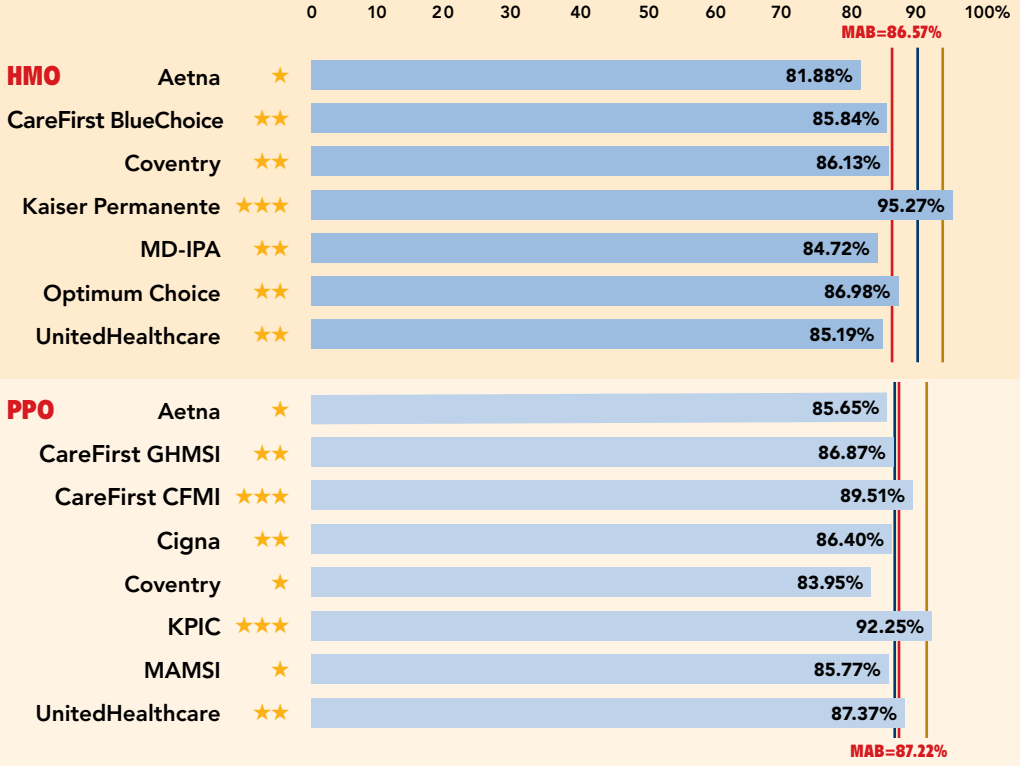
RATIONALE

Diabetes is a serious disease that occurs when the body's level of blood glucose (sugar) is too high. Two main types of diabetes include Type 1, where one's body does not make the insulin needed to convert glucose to energy, and Type 2, where one's body does not make enough insulin or does not use it well. Important tools to gain control over diabetes include:

- Dilated Eye Exam – inspects the delicate retina in the back of the eye for diabetes-related damage
- Cholesterol Test – measures the amount of lipids (fats) in your blood; high levels can lead to blocked arteries
- Urine and Blood Tests – used to check for developing problems in the kidneys
- Blood Pressure Check – measures pressure in your arteries; high blood pressure can lead to heart disease or stroke
- Healthy lifestyle choices, plus foot and dental exams are also important

National Diabetes Education Program, 2009
U.S. Department of Health and Human Services

HbA1c TESTING (DIABETES) – 18 TO 75 YEARS OF AGE



More stars indicate better health benefit plan performance.

The "stars" represent the relative comparisons between the health benefit plans and the Maryland Average Benchmark.

PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: HEDIS® Submission or Health Benefit Plan Records

Comprehensive Diabetes Care continued

DESCRIPTION

2. Hemoglobin A1c (HbA1c) Poor Control >9.0%: The percentage of adults aged 18 to 75 years in 2013 with diabetes (Type 1 and Type 2) who had HbA1c testing during the 2013 measurement year and also had exhibited poor HbA1c control >9.0%.

For this performance indicator, a lower percentage indicates better performance, which means that fewer diabetic adults 18 to 75 years of age exhibited poor control of their HbA1c level, thereby indicating better diabetes management.

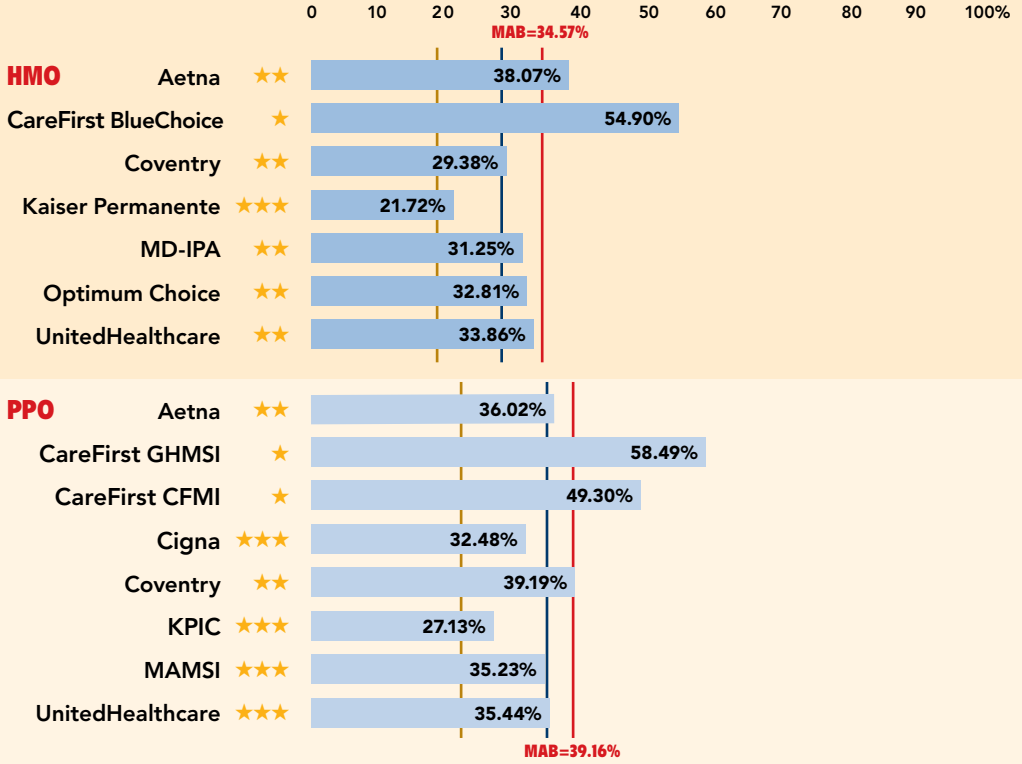
RATIONALE

Diabetes is a serious disease that occurs when the body's level of blood glucose (sugar) is too high. Two main types of diabetes include Type 1, where one's body does not make the insulin needed to convert glucose to energy, and Type 2, where one's body does not make enough insulin or does not use it well. Important tools to gain control over diabetes include:

- Dilated Eye Exam – inspects the delicate retina in the back of the eye for diabetes-related damage
- Cholesterol Test – measures the amount of lipids (fats) in your blood; high levels can lead to blocked arteries
- Urine and Blood Tests – used to check for developing problems in the kidneys
- Blood Pressure Check – measures pressure in your arteries; high blood pressure can lead to heart disease or stroke
- Healthy lifestyle choices, plus foot and dental exams are also important

National Diabetes Education Program, 2009
U.S. Department of Health and Human Services

HbA1c POOR CONTROL (DIABETES) >9.0% – 18 TO 75 YEARS OF AGE



More stars indicate better health benefit plan performance.

The "stars" represent the relative comparisons between the health benefit plans and the Maryland Average Benchmark.

PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

NOTE: For this performance indicator, a lower percentage is better

Data Source: HEDIS® Submission or Health Benefit Plan Records

Comprehensive Diabetes Care continued

DESCRIPTION

3. Hemoglobin A1c (HbA1c) Good Control <8.0%: The percentage of adults 18 to 75 years in 2013 with diabetes (Type 1 and Type 2) who had HbA1c testing during the 2013 measurement year and also had exhibited good HbA1c control <8.0%.

For this performance indicator, a higher percentage is better, which means that more diabetic adults 18 to 75 years of age exhibited good control of their HbA1c level, thereby indicating better diabetes management.

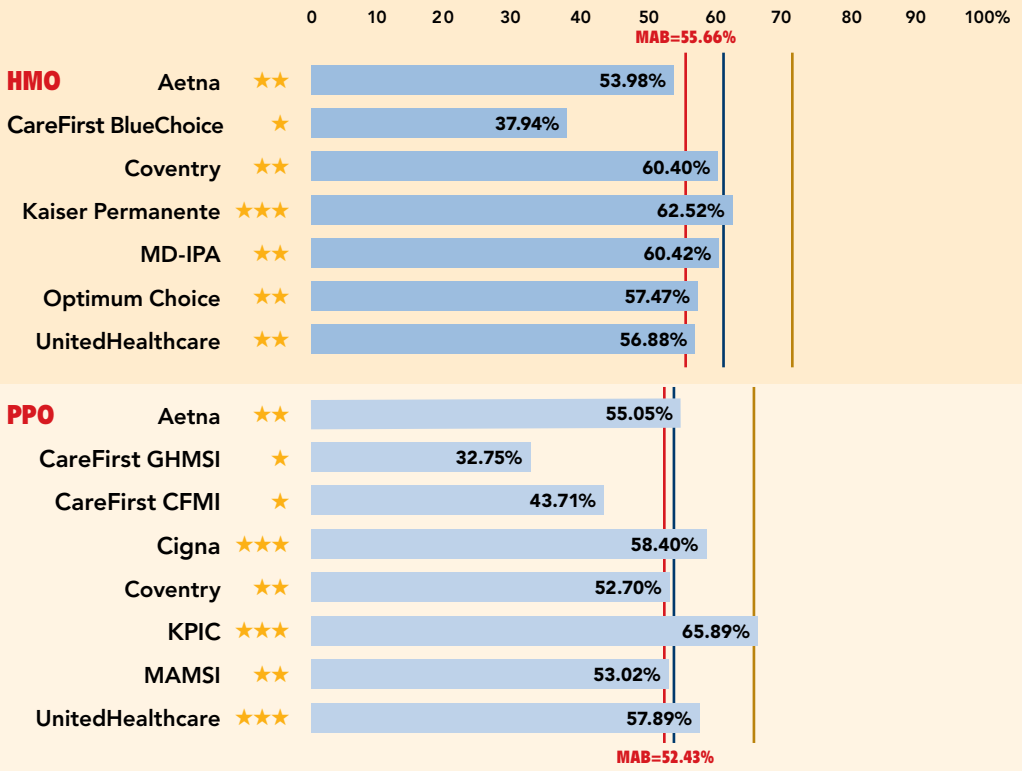
RATIONALE

Diabetes is a serious disease that occurs when the body's level of blood glucose (sugar) is too high. Two main types of diabetes include Type 1, where one's body does not make the insulin needed to convert glucose to energy, and Type 2, where one's body does not make enough insulin or does not use it well. Important tools to gain control over diabetes include:

- Dilated Eye Exam – inspects the delicate retina in the back of the eye for diabetes-related damage
- Cholesterol Test – measures the amount of lipids (fats) in your blood; high levels can lead to blocked arteries
- Urine and Blood Tests – used to check for developing problems in the kidneys
- Blood Pressure Check – measures pressure in your arteries; high blood pressure can lead to heart disease or stroke
- Healthy lifestyle choices, plus foot and dental exams are also important

National Diabetes Education Program, 2009
U.S. Department of Health and Human Services

HbA1c GOOD CONTROL (DIABETES) <8.0% – 18 TO 75 YEARS OF AGE



More stars indicate better health benefit plan performance.

The "stars" represent the relative comparisons between the health benefit plans and the Maryland Average Benchmark.

PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: HEDIS® Submission or Health Benefit Plan Records

Comprehensive Diabetes Care continued

DESCRIPTION

4. Hemoglobin A1c (HbA1c) Tight Control <7.0%: The percentage of adults aged 18 to 75 years in 2013 with diabetes (Type 1 and Type 2) who had HbA1c testing during the 2013 measurement year and also had exhibited tight HbA1c control <7.0%.

For this performance indicator, a higher percentage is better, which means that more diabetic adults 18 to 75 years of age exhibited tight control of their HbA1c level, thereby indicating better diabetes management.

NOTE: Additional exclusion criteria may apply (e.g., members aged 65 years and over as of December 31 of the 2013 measurement year, discharged alive for coronary artery bypass graft procedure during the 2013 measurement year or the year prior, etc.).

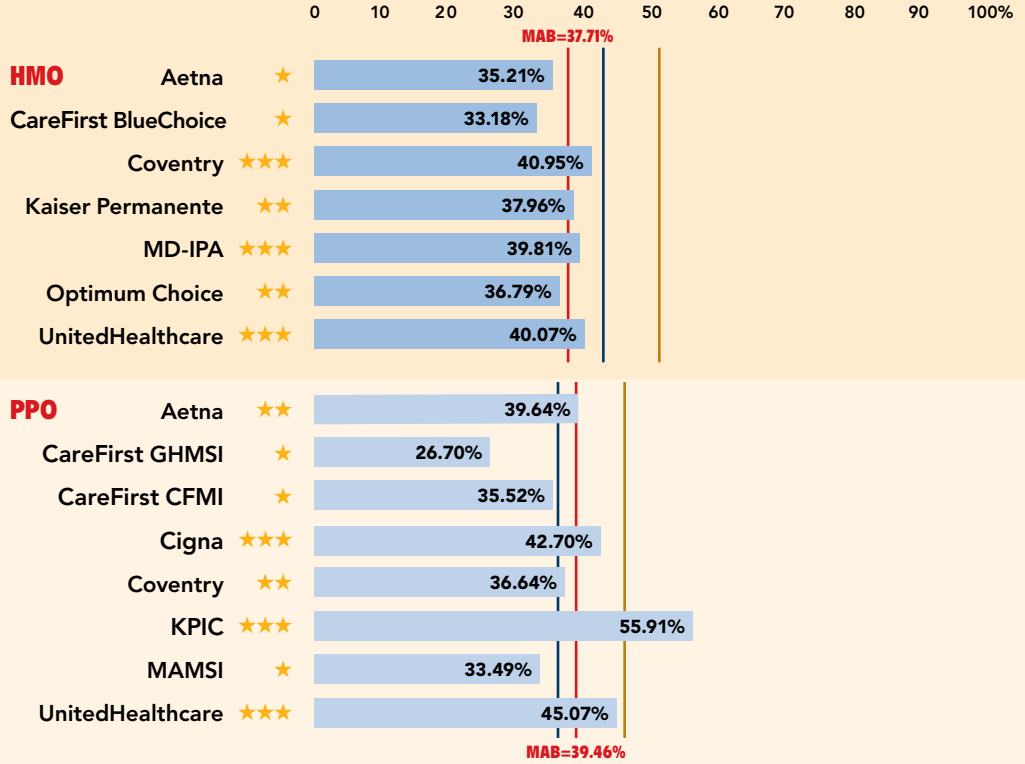
RATIONALE

Diabetes is a serious disease that occurs when the body's level of blood glucose (sugar) is too high. Two main types of diabetes include Type 1, where one's body does not make the insulin needed to convert glucose to energy, and Type 2, where one's body does not make enough insulin or does not use it well. Important tools to gain control over diabetes include:

- Dilated Eye Exam – inspects the delicate retina in the back of the eye for diabetes-related damage
- Cholesterol Test – measures the amount of lipids (fats) in your blood; high levels can lead to blocked arteries
- Urine and Blood Tests – used to check for developing problems in the kidneys
- Blood Pressure Check – measures pressure in your arteries; high blood pressure can lead to heart disease or stroke
- Healthy lifestyle choices, plus foot and dental exams are also important

National Diabetes Education Program, 2009
U.S. Department of Health and Human Services

HbA1c TIGHT CONTROL (DIABETES) <7.0% – 18 TO 75 YEARS OF AGE



More stars indicate better health benefit plan performance.

The "stars" represent the relative comparisons between the health benefit plans and the Maryland Average Benchmark.

PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: HEDIS® Submission or Health Benefit Plan Records

Comprehensive Diabetes Care continued

DESCRIPTION

5. Dilated Eye Exam (Retina) Performed: The percentage of adults 18 to 75 years in 2013 with diabetes (Type 1 and Type 2) who had a retinal eye exam during the 2013 measurement year.

For this performance indicator, a higher percentage is better, which means that more diabetic adults 18 to 75 years of age did get appropriate retinal examination of the eyes to look for signs of retinopathy, or damage to the blood vessels in the retina, located in the back of the eye.

NOTE: If a patient is negative for retinopathy, they are considered to be at low risk and are not required to have a dilated eye exam by a specialist until the second year after the exam that produced the negative result.

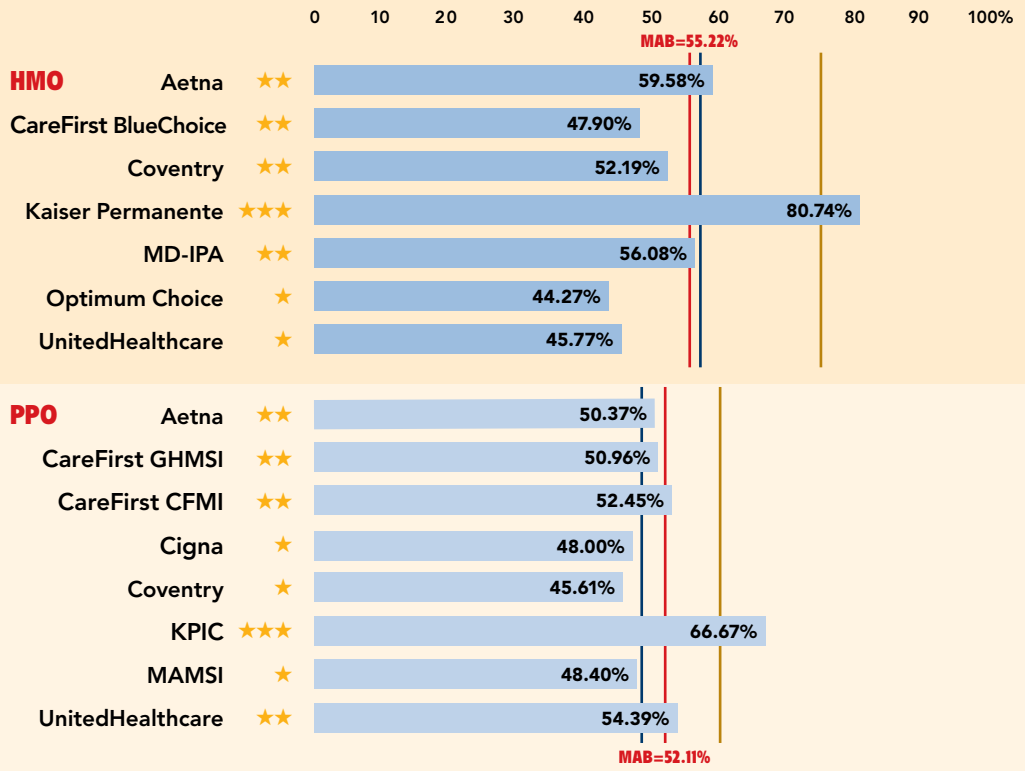
RATIONALE

Diabetes is a serious disease that occurs when the body's level of blood glucose (sugar) is too high. Two main types of diabetes include Type 1, where one's body does not make the insulin needed to convert glucose to energy, and Type 2, where one's body does not make enough insulin or does not use it well. Important tools to gain control over diabetes include:

- Dilated Eye Exam – inspects the delicate retina in the back of the eye for diabetes-related damage
- Cholesterol Test – measures the amount of lipids (fats) in your blood; high levels can lead to blocked arteries
- Urine and Blood Tests – used to check for developing problems in the kidneys
- Blood Pressure Check – measures pressure in your arteries; high blood pressure can lead to heart disease or stroke
- Healthy lifestyle choices, plus foot and dental exams are also important

National Diabetes Education Program, 2009
U.S. Department of Health and Human Services

DILATED EYE EXAM – RETINA (DIABETES) – 18 TO 75 YEARS OF AGE



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PERFORMANCE RATING

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BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: HEDIS® Submission or Health Benefit Plan Records

Comprehensive Diabetes Care continued

DESCRIPTION

6. Low-Density Lipoprotein Cholesterol (LDL-C) Screening: The percentage of adults aged 18 to 75 years in 2013 with diabetes (Type 1 and Type 2) who had a LDL-C screening during the 2013 measurement year.

For this performance indicator, a higher percentage is better, which means that more diabetic adults 18 to 75 years of age did get appropriate LDL cholesterol screening.

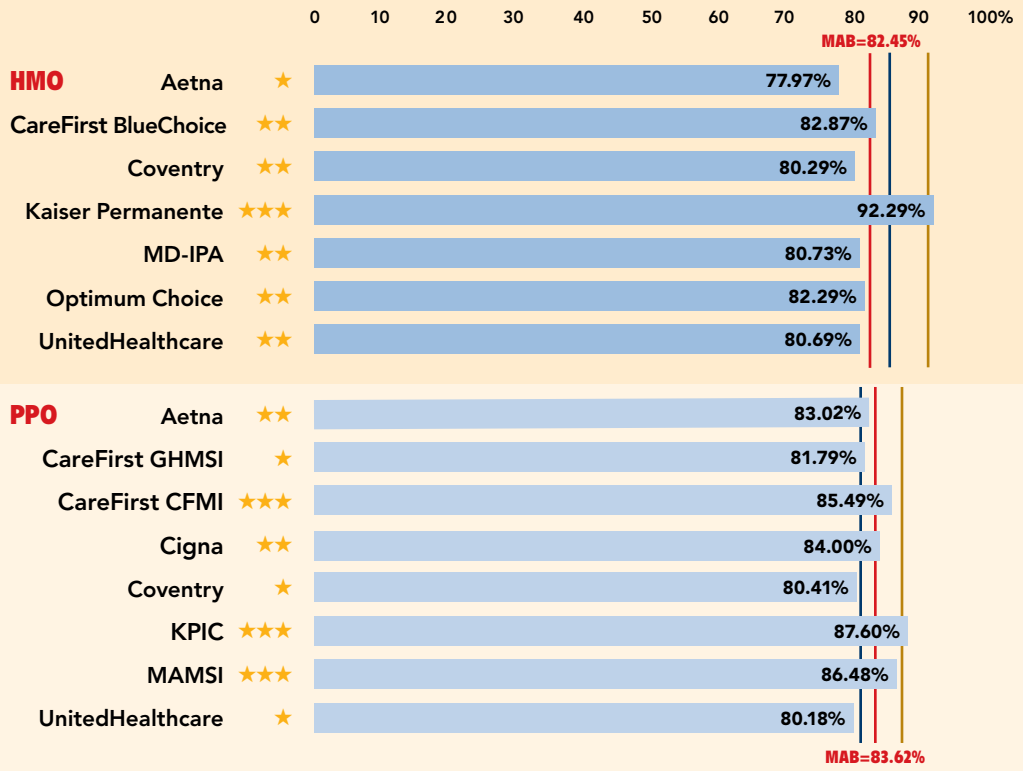
RATIONALE

Diabetes is a serious disease that occurs when the body's level of blood glucose (sugar) is too high. Two main types of diabetes include Type 1, where one's body does not make the insulin needed to convert glucose to energy, and Type 2, where one's body does not make enough insulin or does not use it well. Important tools to gain control over diabetes include:

- Dilated Eye Exam – inspects the delicate retina in the back of the eye for diabetes-related damage
- Cholesterol Test – measures the amount of lipids (fats) in your blood; high levels can lead to blocked arteries
- Urine and Blood Tests – used to check for developing problems in the kidneys
- Blood Pressure Check – measures pressure in your arteries; high blood pressure can lead to heart disease or stroke
- Healthy lifestyle choices, plus foot and dental exams are also important

National Diabetes Education Program, 2009
U.S. Department of Health and Human Services

LDL CHOLESTEROL SCREENING (DIABETES) – 18 TO 75 YEARS OF AGE



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PERFORMANCE RATING

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BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: HEDIS® Submission or Health Benefit Plan Records

Comprehensive Diabetes Care continued

DESCRIPTION

7. Low-Density Lipoprotein Cholesterol (LDL-C) Control <100 mg/dL: The percentage of adults aged 18 to 75 years in 2013 with diabetes (Type 1 and Type 2) who had an LDL-C screening during the 2013 measurement year, and who also had a cholesterol level less than 100 mg/dL on their LDL-C screening.

For this performance indicator, a higher percentage is better, which means that more diabetic adults 18 to 75 years of age do have good control of their cholesterol level.

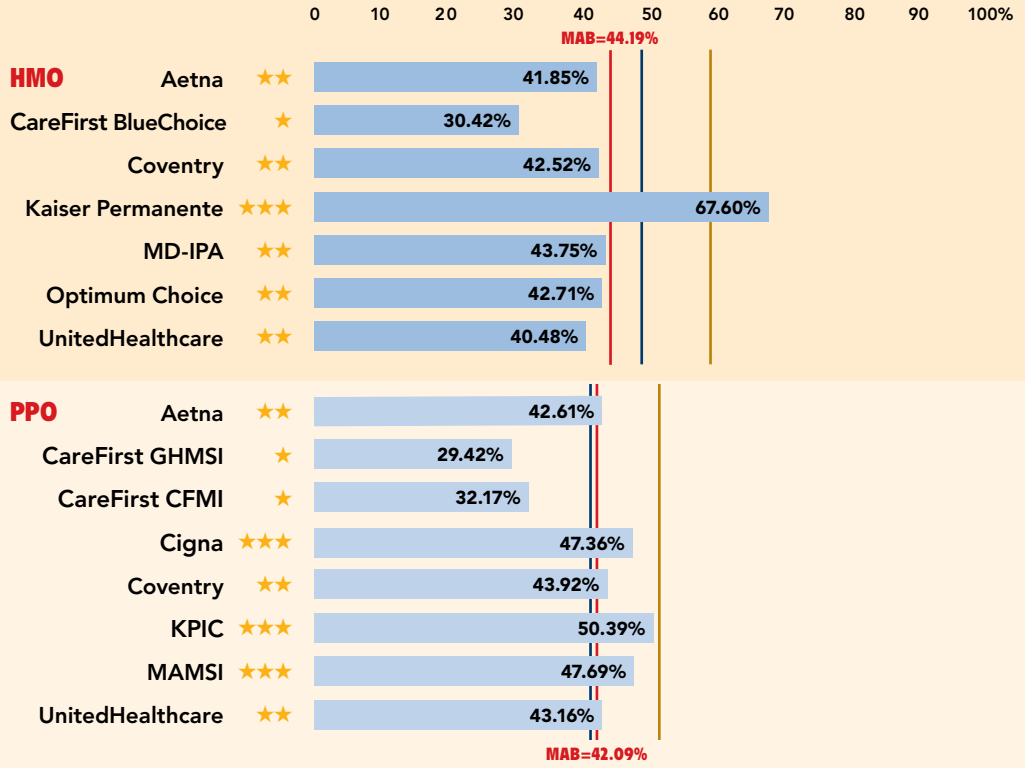
RATIONALE

Diabetes is a serious disease that occurs when the body's level of blood glucose (sugar) is too high. Two main types of diabetes include Type 1, where one's body does not make the insulin needed to convert glucose to energy, and Type 2, where one's body does not make enough insulin or does not use it well. Important tools to gain control over diabetes include:

- Dilated Eye Exam – inspects the delicate retina in the back of the eye for diabetes-related damage
- Cholesterol Test – measures the amount of lipids (fats) in your blood; high levels can lead to blocked arteries
- Urine and Blood Tests – used to check for developing problems in the kidneys
- Blood Pressure Check – measures pressure in your arteries; high blood pressure can lead to heart disease or stroke
- Healthy lifestyle choices, plus foot and dental exams are also important

National Diabetes Education Program, 2009
U.S. Department of Health and Human Services

LDL CHOLESTEROL CONTROL <100 mg/dL (DIABETES) – 18 TO 75 YEARS OF AGE



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BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: HEDIS® Submission or Health Benefit Plan Records

Comprehensive Diabetes Care continued

DESCRIPTION

8. Medical Attention for Nephropathy: The percentage of adults aged 18 to 75 years in 2013 with diabetes (Type 1 and Type 2) who had medical attention for nephropathy or kidney disease during the 2013 measurement year.

For this performance indicator, a higher percentage is better, which means that more diabetic adults 18 to 75 years of age did get appropriate screening and care for nephropathy.

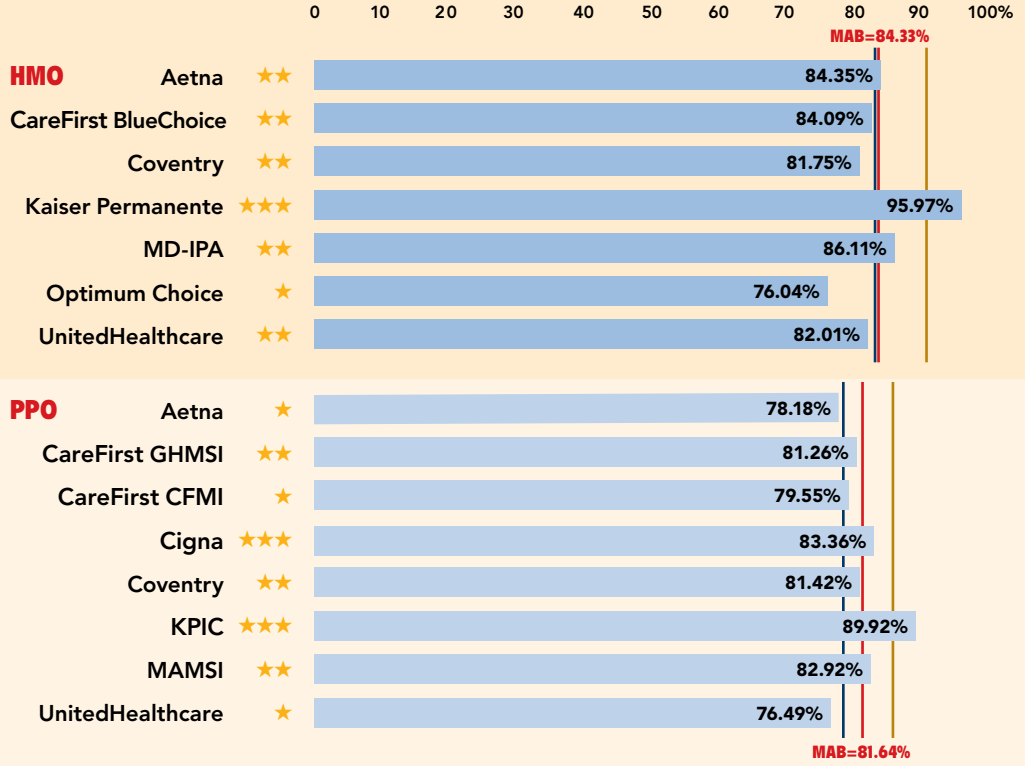
RATIONALE

Diabetes is a serious disease that occurs when the body's level of blood glucose (sugar) is too high. Two main types of diabetes include Type 1, where one's body does not make the insulin needed to convert glucose to energy, and Type 2, where one's body does not make enough insulin or does not use it well. Important tools to gain control over diabetes include:

- Dilated Eye Exam – inspects the delicate retina in the back of the eye for diabetes-related damage
- Cholesterol Test – measures the amount of lipids (fats) in your blood; high levels can lead to blocked arteries
- Urine and Blood Tests – used to check for developing problems in the kidneys
- Blood Pressure Check – measures pressure in your arteries; high blood pressure can lead to heart disease or stroke
- Healthy lifestyle choices, plus foot and dental exams are also important

National Diabetes Education Program, 2009
U.S. Department of Health and Human Services

MEDICAL ATTENTION FOR NEPHROPATHY (DIABETES) – 18 TO 75 YEARS OF AGE



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BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: HEDIS® Submission or Health Benefit Plan Records

Comprehensive Diabetes Care continued

DESCRIPTION

9. Good Blood Pressure Control <140/90 mm Hg: The percentage of adults aged 18 to 75 years in 2013 with diabetes (Type 1 and Type 2) who had their blood pressure assessed and demonstrated good blood pressure control <140/90 mm Hg, during the 2013 measurement year.

For this performance indicator, a higher percentage is better, which means that more diabetic adults 18 to 75 years of age do have good blood pressure control.

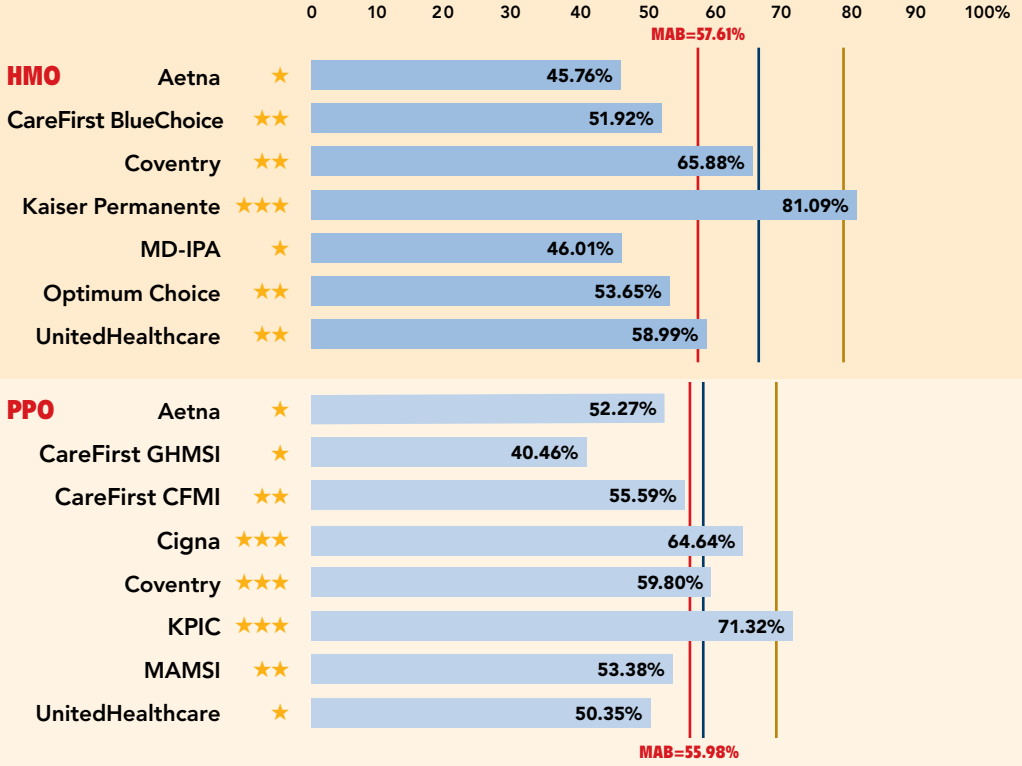
RATIONALE

Diabetes is a serious disease that occurs when the body's level of blood glucose (sugar) is too high. Two main types of diabetes include Type 1, where one's body does not make the insulin needed to convert glucose to energy, and Type 2, where one's body does not make enough insulin or does not use it well. Important tools to gain control over diabetes include:

- Dilated Eye Exam – inspects the delicate retina in the back of the eye for diabetes-related damage
- Cholesterol Test – measures the amount of lipids (fats) in your blood; high levels can lead to blocked arteries
- Urine and Blood Tests – used to check for developing problems in the kidneys
- Blood Pressure Check – measures pressure in your arteries; high blood pressure can lead to heart disease or stroke
- Healthy lifestyle choices, plus foot and dental exams are also important

National Diabetes Education Program, 2009
U.S. Department of Health and Human Services

GOOD BLOOD PRESSURE CONTROL <140/90 mm Hg (DIABETES) – 18 TO 75 YEARS OF AGE



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PERFORMANCE RATING

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BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: HEDIS® Submission or Health Benefit Plan Records

Comprehensive Diabetes Care continued

DESCRIPTION

10. Excellent Blood Pressure Control <140/80 mm Hg: The percentage of adults aged 18 to 75 years in 2013 with diabetes (Type 1 and Type 2) who had their blood pressure assessed and demonstrated excellent blood pressure control <140/80 mm Hg, during the 2013 measurement year.

For this performance indicator, a higher percentage is better, which means that more diabetic adults 18 to 75 years of age do have excellent blood pressure control.

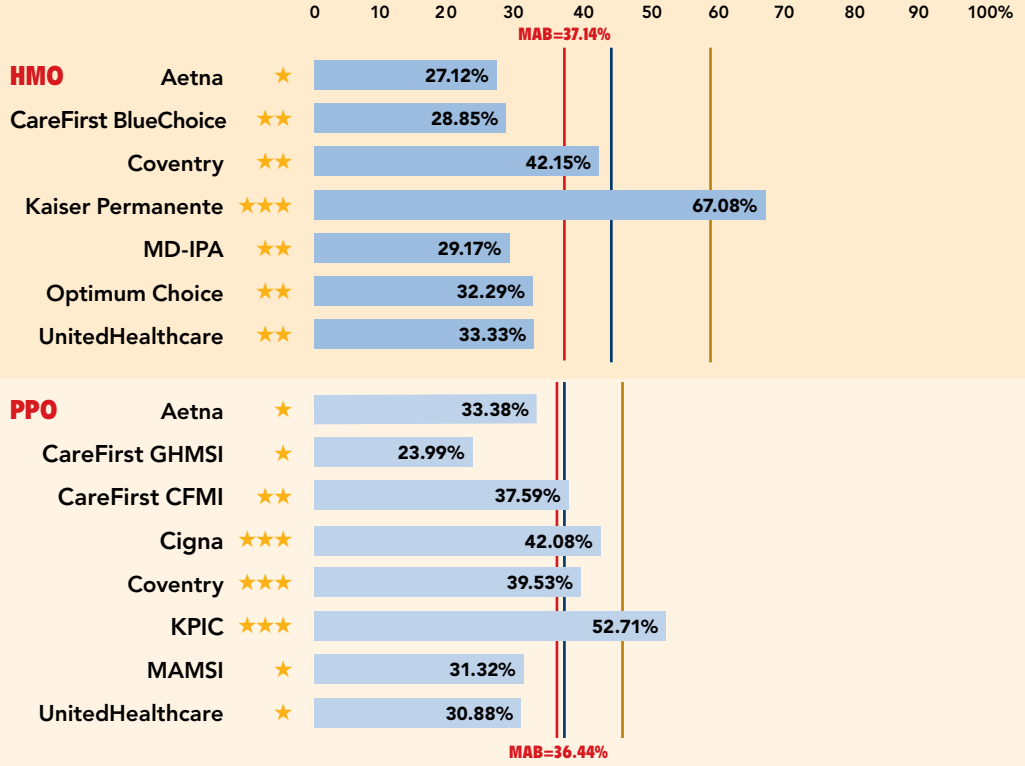
RATIONALE

Diabetes is a serious disease that occurs when the body's level of blood glucose (sugar) is too high. Two main types of diabetes include Type 1, where one's body does not make the insulin needed to convert glucose to energy, and Type 2, where one's body does not make enough insulin or does not use it well. Important tools to gain control over diabetes include:

- Dilated Eye Exam – inspects the delicate retina in the back of the eye for diabetes-related damage
- Cholesterol Test – measures the amount of lipids (fats) in your blood; high levels can lead to blocked arteries
- Urine and Blood Tests – used to check for developing problems in the kidneys
- Blood Pressure Check – measures pressure in your arteries; high blood pressure can lead to heart disease or stroke
- Healthy lifestyle choices, plus foot and dental exams are also important

National Diabetes Education Program, 2009
U.S. Department of Health and Human Services

EXCELLENT BLOOD PRESSURE CONTROL <140/80 mm Hg (DIABETES) – 18 TO 75 YEARS OF AGE



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PERFORMANCE RATING

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BENCHMARKS

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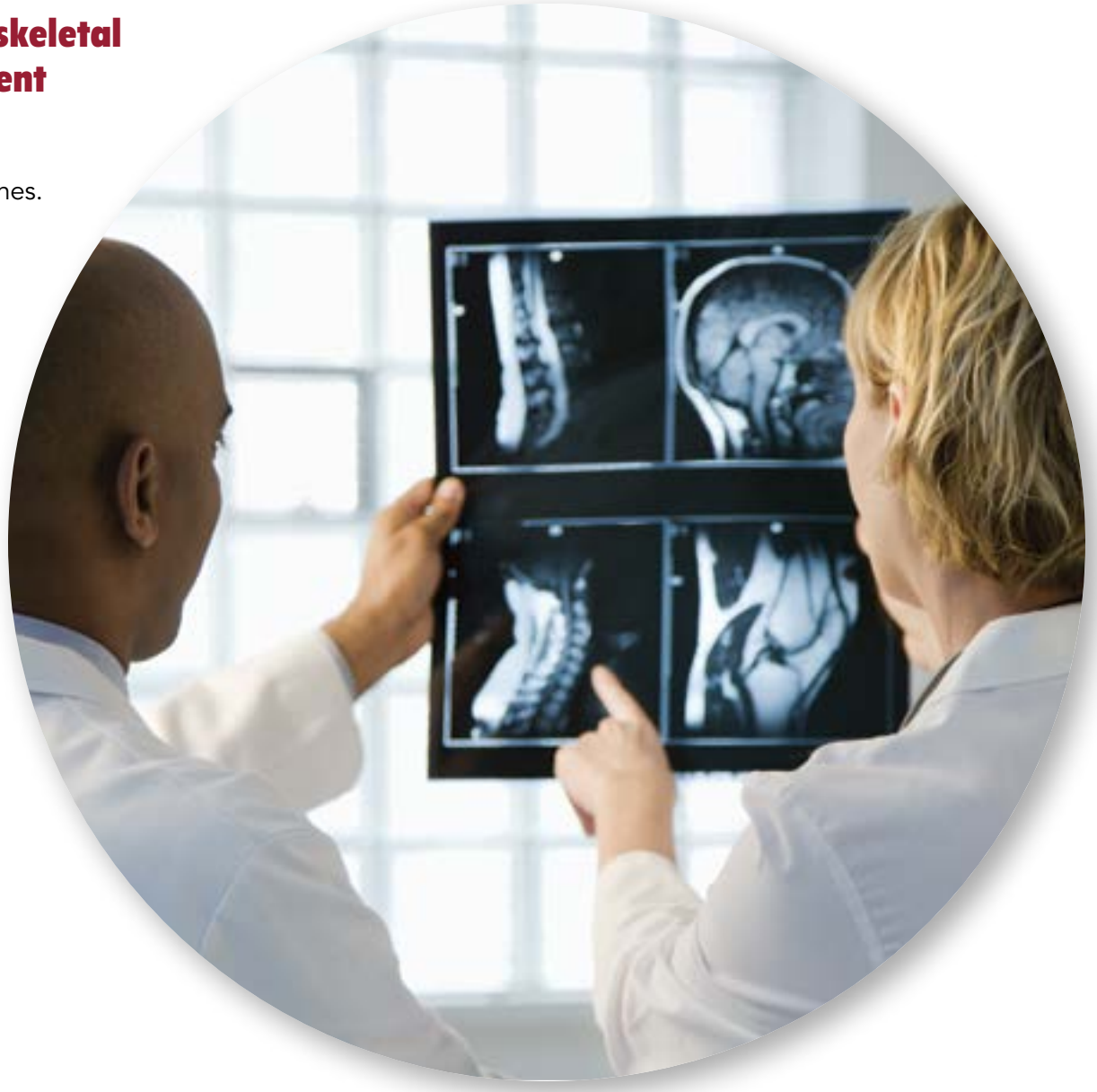
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: HEDIS® Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care for Adults – Musculoskeletal Disease and Medication Management

Musculoskeletal diseases and disorders affect the muscles, tendons and ligaments, as well as the bones. Often, musculoskeletal disorders are due to minor illness or injury and short-term medications are used to relieve pain while the problem gets better. However, more serious diseases and disorders may cause persistent pain, discomfort or disability, and long-term medications are needed to adequately control symptoms and manage the disease or disorder.



Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis

DESCRIPTION

The percentage of adults aged 18 years and over in 2013 who were diagnosed with rheumatoid arthritis (RA) and who were given a prescription for at least one disease modifying anti-rheumatic drug (DMARD) in 2013. DMARDs are medications proven effective in slowing or preventing joint damage as opposed to just relieving pain and inflammation.

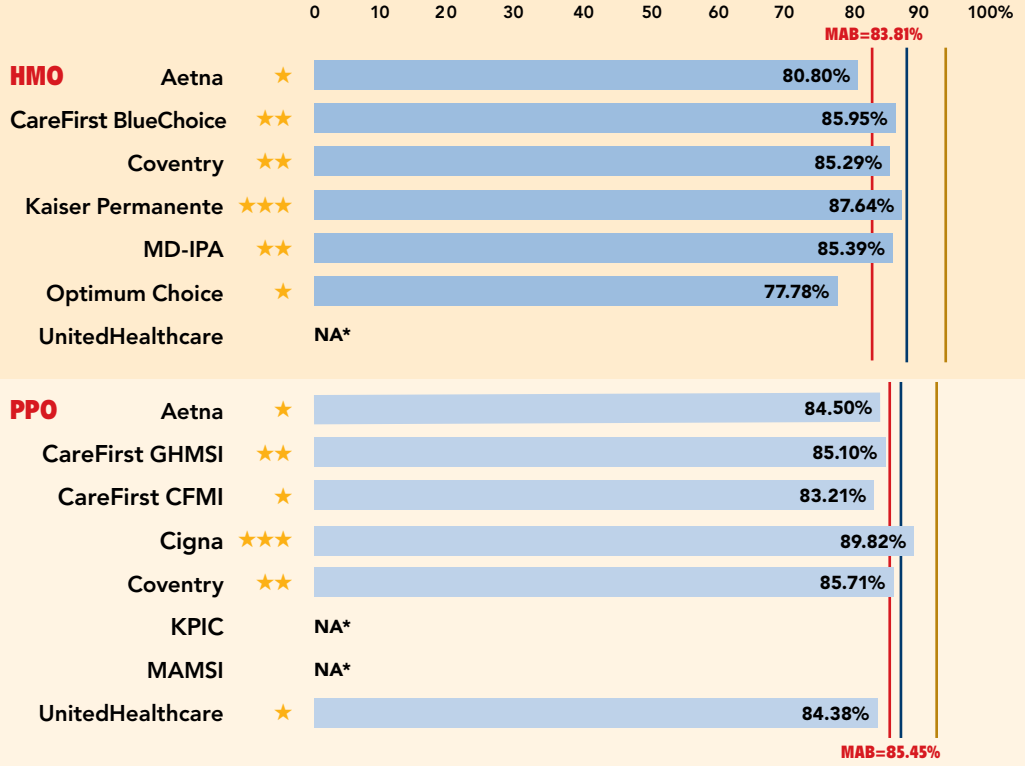
For this measure, a higher percentage is better, which means that more adults 18 years of age and over did get DMARD treatment for their RA.

RATIONALE

The autoimmune condition, rheumatoid arthritis (RA), is a systemic, chronic inflammatory disease that primarily affects the membrane lining of multiple joints, but can also affect organs in the body. The inflamed membrane tissues surrounding affected joints can cause joint redness, swelling, pain, and even joint deformity. There is no cure for RA. The goal is to start treatment early, including medications, therapy and exercise, in order to slow or stop disease progression. Newer non-biologic and biologic Disease Modifying anti-Rheumatic Drugs (DMARDs) help relieve pain, prevent joint destruction and maintain functional capacity. Ideally, DMARD therapy should be started within 3 months of diagnosis.

National Center for Chronic Disease Prevention and Health Promotion, 2012
Centers for Disease Control and Prevention

DMARD THERAPY – 18+ YEARS OF AGE



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PERFORMANCE RATING

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BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

NA* Insufficient eligible members to calculate rate

Data Source: HEDIS® Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

PRIMARY CARE FOR ADULTS – MUSCULOSKELETAL DISEASE AND MEDICATION MANAGEMENT

Use of Imaging Studies for Low Back Pain

DESCRIPTION

The percentage of adults aged 18 to 50 years in 2013 with a primary diagnosis of low back pain who did not have an imaging study (x-ray, MRI or CT scan) within 28 days after the diagnosis.

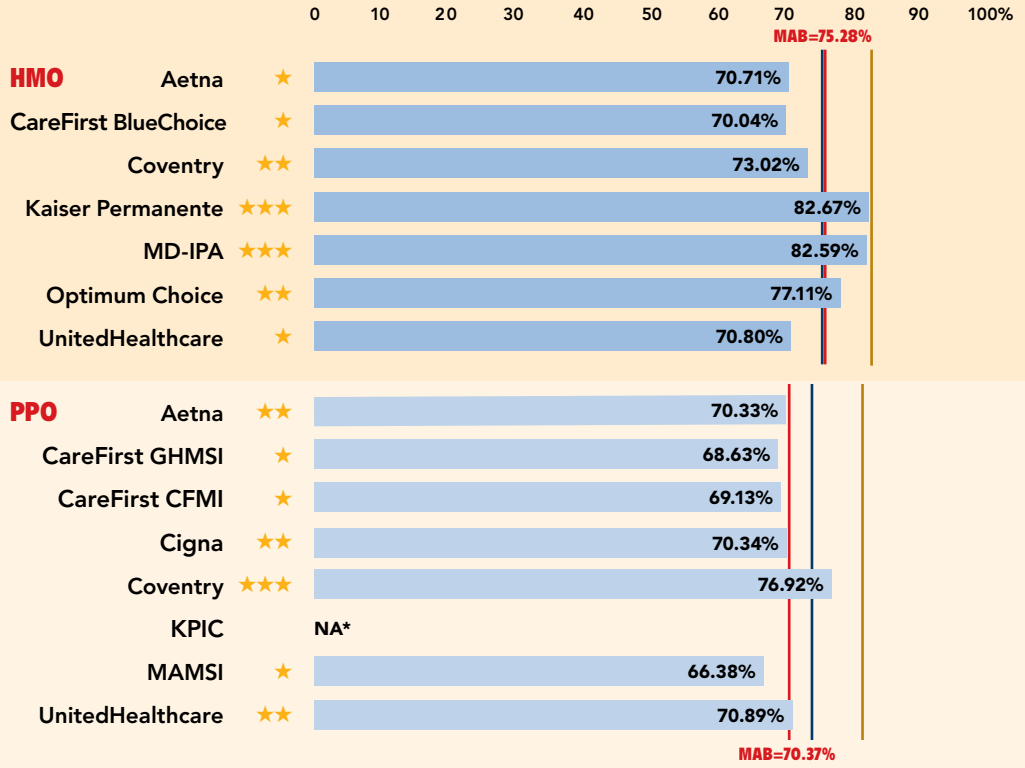
For this measure, a higher percentage is better, which means that more adults 18 to 50 years of age with low back pain appropriately did not get an imaging study, as imaging studies are often overused.

RATIONALE

Low back pain is common, affecting most people at some time in their lives. Since acute back pain usually lasts only 2 to 4 weeks, conservative treatment with medication, physical therapy, exercise, and patient education is generally recommended, except for a few "red flag" cases where a serious cause such as a fracture, infection, tumor, etc. is suspected. Single or multiple views of plain lumbar x-rays which expose the male and female reproductive organs to harmful radiation, are not recommended during the first 4 weeks of treatment.

National Center for Biotechnology Information, 2006
U.S. National Library of Medicine
National Institutes of Health

NO IMAGING WITHIN 28 DAYS AFTER DIAGNOSIS – 18 TO 50 YEARS OF AGE



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BENCHMARKS

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NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: HEDIS® Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

PRIMARY CARE FOR ADULTS – MUSCULOSKELETAL DISEASE AND MEDICATION MANAGEMENT

Annual Monitoring for Patients on Persistent Medications

DESCRIPTION

Each health benefit plan reports on multiple indicators under this measure. Four separate indicators include:

1. Annual Monitoring for Patients on Angiotensin Converting Enzyme (ACE) Inhibitors or Angiotensin Receptor Blockers (ARBs): The percentage of adults aged 18 years and over in 2013 who received at least 180 treatment days of ambulatory medication therapy with ACE inhibitors or ARBs during 2013 and had at least one therapeutic monitoring event for the ACE inhibitor or ARB agent in 2013.

For this performance indicator, a higher percentage is better, which means that more adults 18 years of age and over on ACE inhibitors or ARBs are being appropriately monitored and did get at least one annual therapeutic monitoring event.

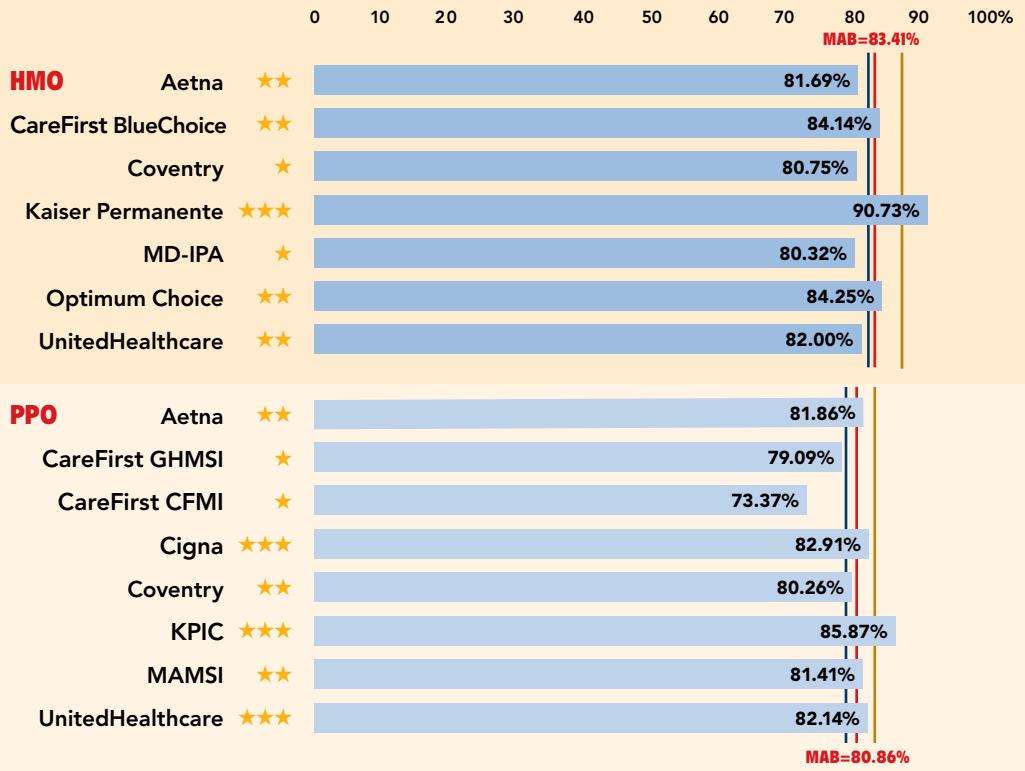
RATIONALE

ACE inhibitors, ARBs, digoxin, diuretics, and anticonvulsants are taken by thousands of patients and are proven to be safe classes of medications. However, over 700,000 emergency department visits each year are due to adverse drug events. The risk of having an adverse drug event is increased among older adults who typically take more medicines. Some medicines that require regular monitoring include:

- Blood thinners (e.g., warfarin)
- Diabetes medicines (e.g., insulin)
- Seizure/Anticonvulsant medicines (e.g., phenytoin, carbamazepine)
- Heart medicine (e.g., digoxin)
- Blood pressure medicines (e.g., ACE inhibitors, ARBs and diuretics

Division of Healthcare Quality Promotion, 2012
Centers for Disease Control and Prevention

ACE INHIBITORS OR ARBS – 18+ YEARS OF AGE



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BENCHMARKS

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NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: HEDIS® Submission or Health Benefit Plan Records

Annual Monitoring for Patients on Persistent Medications continued

DESCRIPTION

2. Annual Monitoring for Patients on Digoxin: The percentage of adults aged 18 years and over in 2013 who received at least 180 treatment days of ambulatory medication therapy with Digoxin during 2013 and had at least one therapeutic monitoring event for the Digoxin agent in 2013.

For this performance indicator, a higher percentage is better, which means that more adults 18 years of age and over on Digoxin are being appropriately monitored and did get at least one annual therapeutic monitoring event.

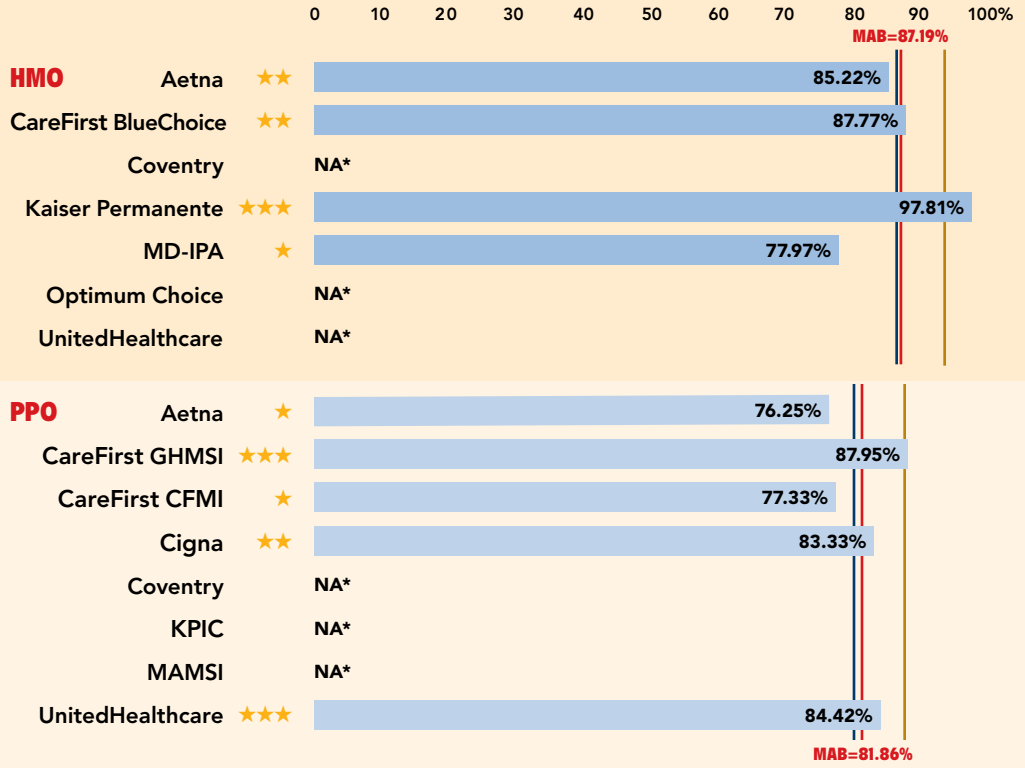
RATIONALE

ACE inhibitors, ARBs, digoxin, diuretics, and anticonvulsants are taken by thousands of patients and are proven to be safe classes of medications. However, over 700,000 emergency department visits each year are due to adverse drug events. The risk of having an adverse drug event is increased among older adults who typically take more medicines. Some medicines that require regular monitoring include:

- Blood thinners (e.g., warfarin)
- Diabetes medicines (e.g., insulin)
- Seizure/Anticonvulsant medicines (e.g., phenytoin, carbamazepine)
- Heart medicine (e.g., digoxin)
- Blood pressure medicines (e.g., ACE inhibitors, ARBs and diuretics

Division of Healthcare Quality Promotion, 2012
Centers for Disease Control and Prevention

DIGOXIN – 18+ YEARS OF AGE



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BENCHMARKS

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NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

NA* Insufficient eligible members to calculate rate

Data Source: HEDIS® Submission or Health Benefit Plan Records

Annual Monitoring for Patients on Persistent Medications continued

DESCRIPTION

3. Annual Monitoring for Patients on Diuretics: The percentage of adults aged 18 years and over in 2013 who received at least 180 treatment days of ambulatory medication therapy with diuretics during 2013 and had at least one therapeutic monitoring event for the diuretic agent in 2013.

For this performance indicator, a higher percentage is better, which means that more adults 18 years of age and over on diuretics are being appropriately monitored and did get at least one annual therapeutic monitoring event.

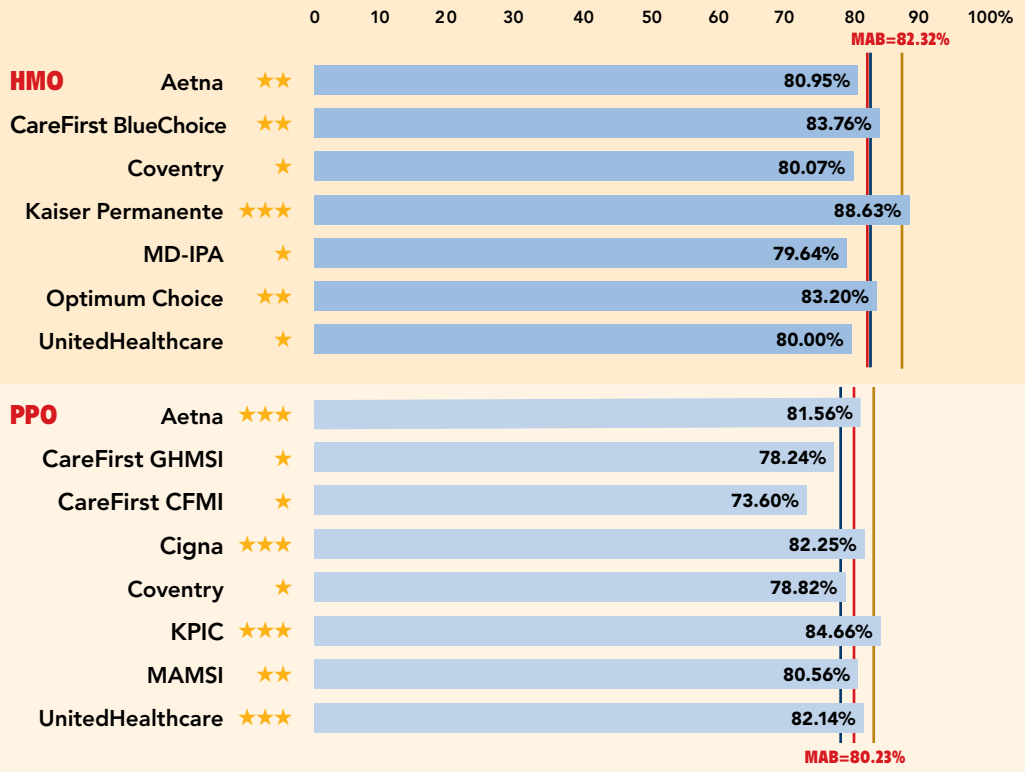
RATIONALE

ACE inhibitors, ARBs, digoxin, diuretics, and anticonvulsants are taken by thousands of patients and are proven to be safe classes of medications. However, over 700,000 emergency department visits each year are due to adverse drug events. The risk of having an adverse drug event is increased among older adults who typically take more medicines. Some medicines that require regular monitoring include:

- Blood thinners (e.g., warfarin)
- Diabetes medicines (e.g., insulin)
- Seizure/Anticonvulsant medicines (e.g., phenytoin, carbamazepine)
- Heart medicine (e.g., digoxin)
- Blood pressure medicines (e.g., ACE inhibitors, ARBs and diuretics

Division of Healthcare Quality Promotion, 2012
Centers for Disease Control and Prevention

DIURETICS – 18+ YEARS OF AGE



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BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: HEDIS® Submission or Health Benefit Plan Records

Annual Monitoring for Patients on Persistent Medications continued

DESCRIPTION

4. Annual Monitoring for Patients on Anticonvulsants: The percentage of adults aged 18 years and over in 2013 who received at least 180 treatment days of ambulatory medication therapy with anticonvulsants during 2013 and had at least one therapeutic monitoring event for the anticonvulsant agent in 2013.

For this performance indicator, a higher percentage is better, which means that more adults 18 years of age and over on anticonvulsants are being appropriately monitored and did get at least one annual therapeutic monitoring event.

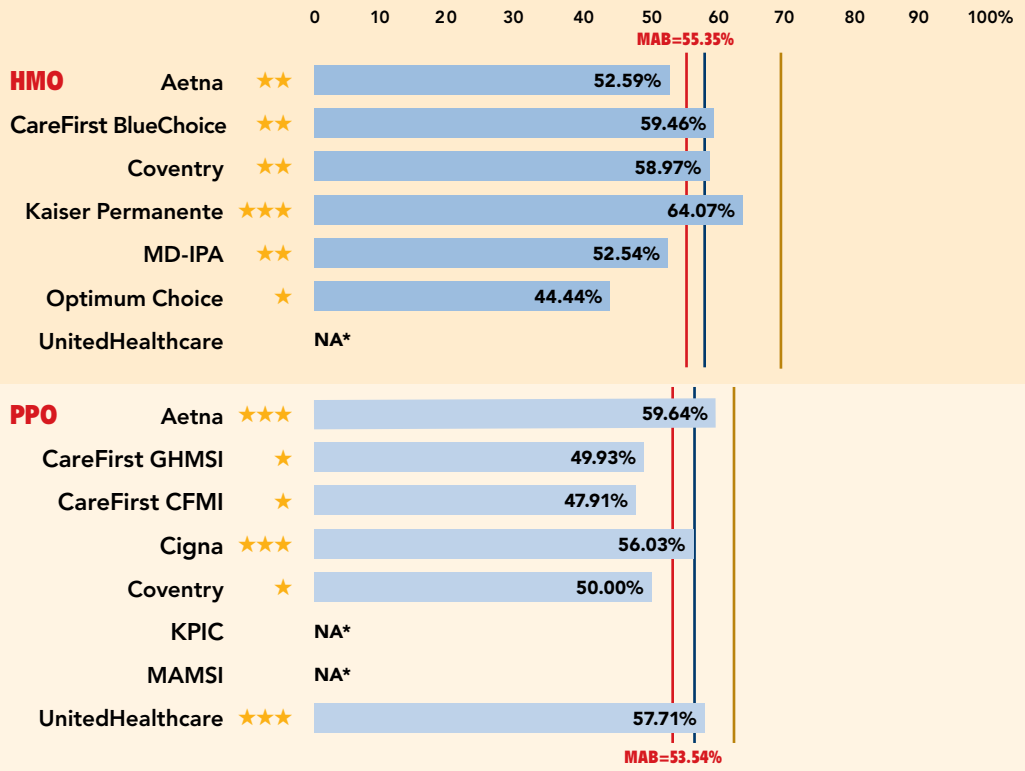
RATIONALE

ACE inhibitors, ARBs, digoxin, diuretics, and anticonvulsants are taken by thousands of patients and are proven to be safe classes of medications. However, over 700,000 emergency department visits each year are due to adverse drug events. The risk of having an adverse drug event is increased among older adults who typically take more medicines. Some medicines that require regular monitoring include:

- Blood thinners (e.g., warfarin)
- Diabetes medicines (e.g., insulin)
- Seizure/Anticonvulsant medicines (e.g., phenytoin, carbamazepine)
- Heart medicine (e.g., digoxin)
- Blood pressure medicines (e.g., ACE inhibitors, ARBs and diuretics

Division of Healthcare Quality Promotion, 2012
Centers for Disease Control and Prevention

ANTICONVULSANTS – 18+ YEARS OF AGE



More stars indicate better health benefit plan performance.

The "stars" represent the relative comparisons between the health benefit plans and the Maryland Average Benchmark.

PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

NA* Insufficient eligible members to calculate rate

Data Source: HEDIS® Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Behavioral Health

The intent of these measures is to maintain functionality for a patient, to appropriately utilize health care resources and to protect a patient on long term medication from harmful use. Treatment and medication is not required in every case, but when it is, a patient should be made aware of the short and long term effects.

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

BEHAVIORAL HEALTH

Antidepressant Medication Management

DESCRIPTION

Each health benefit plan reports on multiple indicators under this measure. Two separate indicators include:

1. Effective Acute Phase Treatment: The percentage of adults aged 18 years and over in 2013 with a diagnosis of major depression who were newly treated with antidepressant medication, and who remained on an antidepressant medication for at least 84 days (12 weeks).

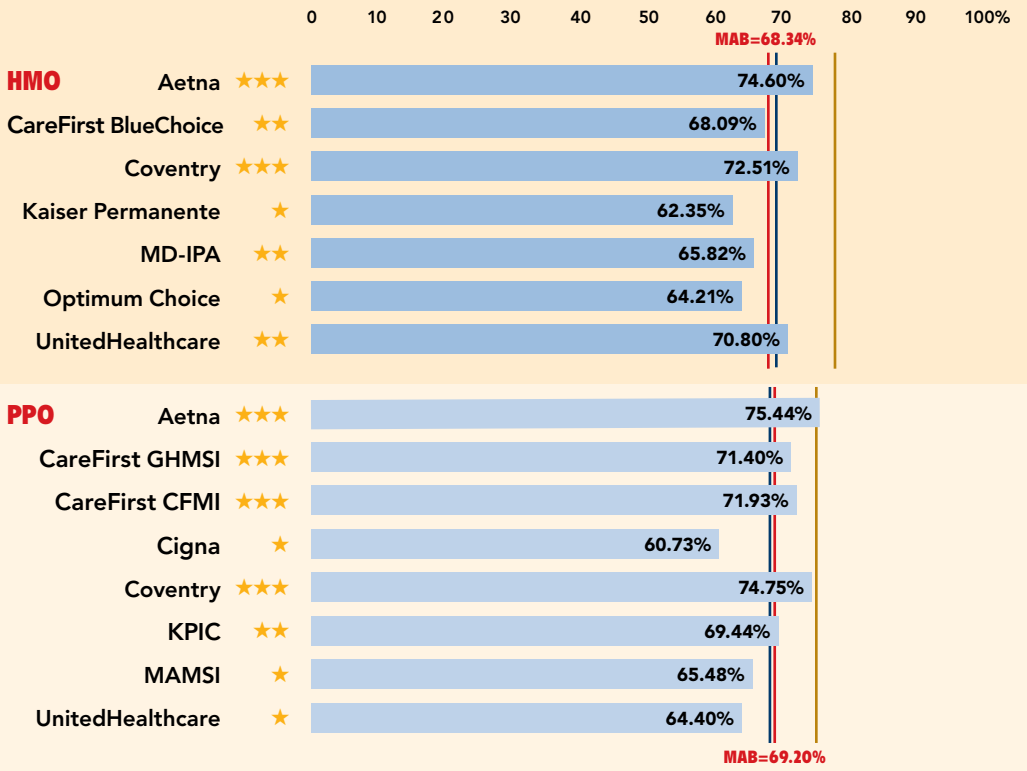
For this performance indicator, a higher percentage is better, which means that more adults 18 years of age and over with depression were effectively treated with 12 weeks of antidepressant medication during the acute phase of treatment.

RATIONALE

Major depression often goes untreated with many people having to endure symptoms that can last for years and which sometimes can lead to tragic consequences such as suicide. However, treatment with antidepressant medication and/or behavioral health therapy has proven to be effective. Due to the potential for serious side effects, patients on antidepressant medication should be closely monitored not only for the safety and effectiveness of the medication, but also for compliance with taking the medication as prescribed and for any unwanted side effects.

National Guideline Clearinghouse
Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services

EFFECTIVE 12 WEEK ACUTE PHASE – 18+ YEARS OF AGE



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PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: HEDIS® Submission or Health Benefit Plan Records

Antidepressant Medication Management continued

DESCRIPTION

2. Effective Continuation Phase Treatment: The percentage of adults aged 18 years and over in 2013 with a diagnosis of major depression who were newly treated with antidepressant medication, and who remained on an antidepressant medication for at least 180 days (6 months).

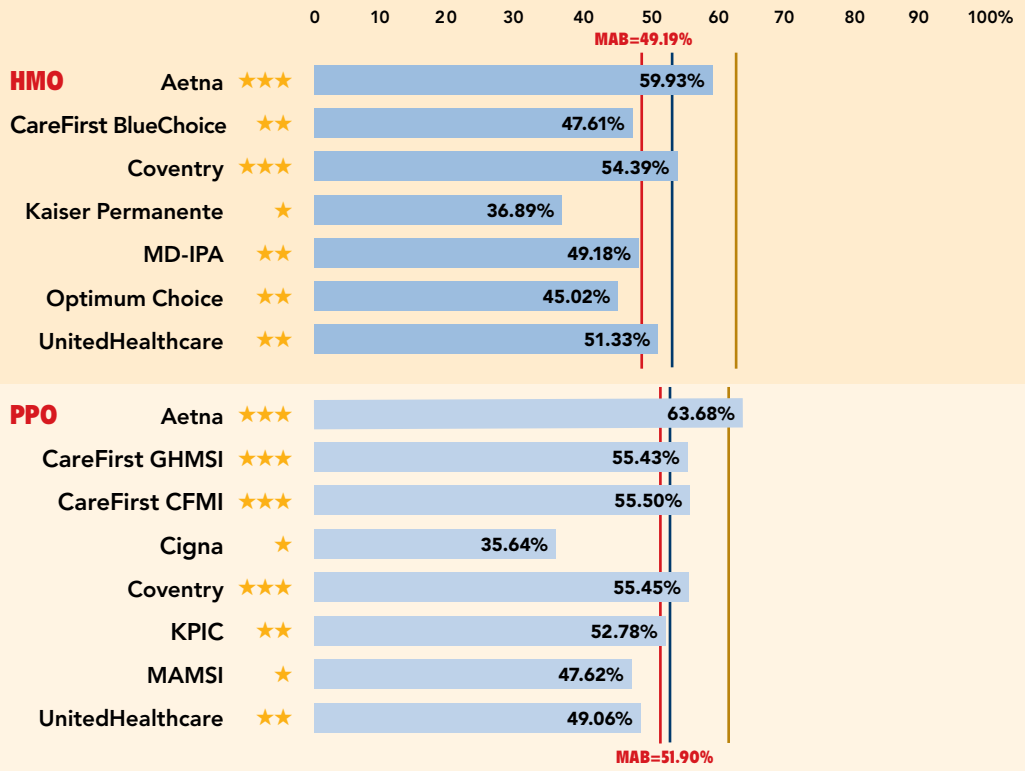
For this performance indicator, a higher percentage is better, which means that more adults 18 years of age and over with depression were effectively treated with at least 6 months of antidepressant medication during the continuation phase of treatment.

RATIONALE

Major depression often goes untreated with many people having to endure symptoms that can last for years and which sometimes can lead to tragic consequences such as suicide. However, treatment with antidepressant medication and/or behavioral health therapy has proven to be effective. Due to the potential for serious side effects, patients on antidepressant medication should be closely monitored not only for the safety and effectiveness of the medication, but also for compliance with taking the medication as prescribed and for any unwanted side effects.

National Guideline Clearinghouse
Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services

EFFECTIVE 6 MONTH CONTINUATION PHASE – 18+ YEARS OF AGE



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PERFORMANCE RATING

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★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: HEDIS® Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

BEHAVIORAL HEALTH

Follow-Up After Hospitalization for Mental Illness

DESCRIPTION

Each health benefit plan reports on multiple indicators under this measure. Two separate indicators include:

1. Follow-Up Within 7 Days of Discharge: The percentage of members aged 6 years and over in 2013 who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner for which the member received follow-up within 7 days of discharge.

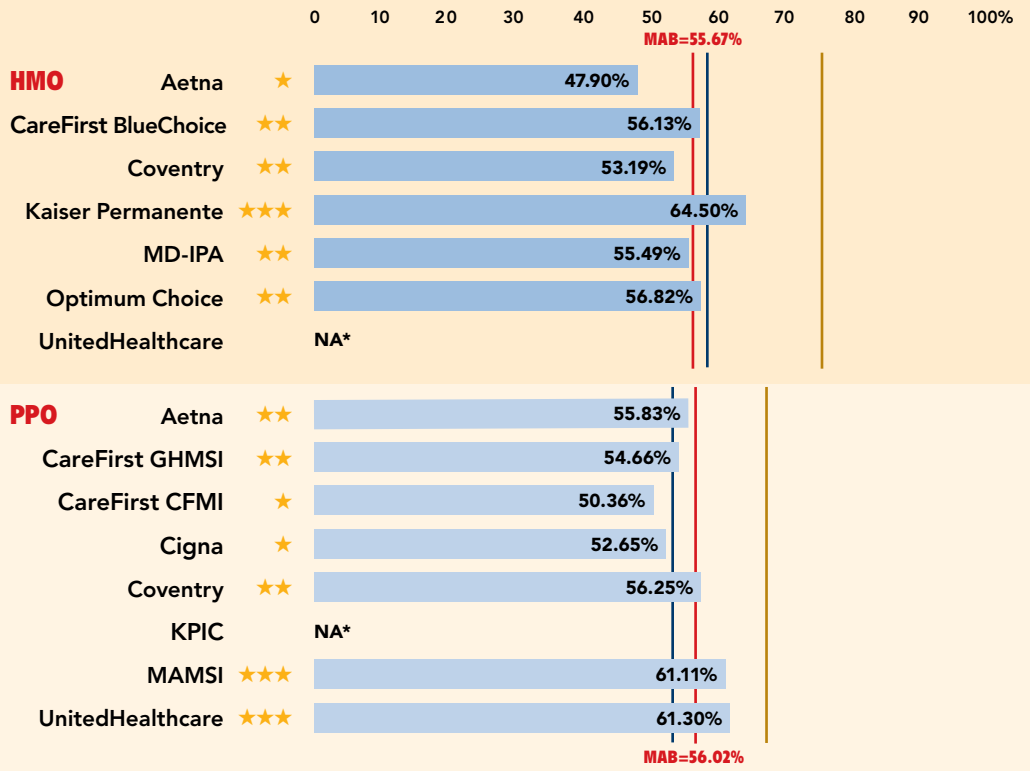
For this performance indicator, a higher percentage is better, which means that more members 6 years of age and over who were hospitalized for treatment of selected mental health disorders received timely follow-up within 7 days of discharge.

RATIONALE

It is important to provide regular follow-up therapy to patients after they have been hospitalized for mental illness. Outpatient visits with a behavioral health care provider that begin soon after discharge are recommended to make sure that the patient's transition to the home or work environment is supported and that gains made during hospitalization are not lost. It also helps behavioral health care providers to detect early post-hospitalization reactions or medication problems and provide appropriate interventions.

National Institute of Mental Health
National Institutes of Health

FOLLOW-UP WITHIN 7 DAYS – 6+ YEARS OF AGE



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PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

NA* Insufficient eligible members (fewer than 30) to calculate rate

Data Source: HEDIS® Submission or Health Benefit Plan Records

Follow-Up After Hospitalization for Mental Illness
continued

DESCRIPTION

2. Follow-Up Within 30 Days of Discharge: The percentage of members aged 6 years and over in 2013 who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner for which the member received follow-up within 30 days of discharge.

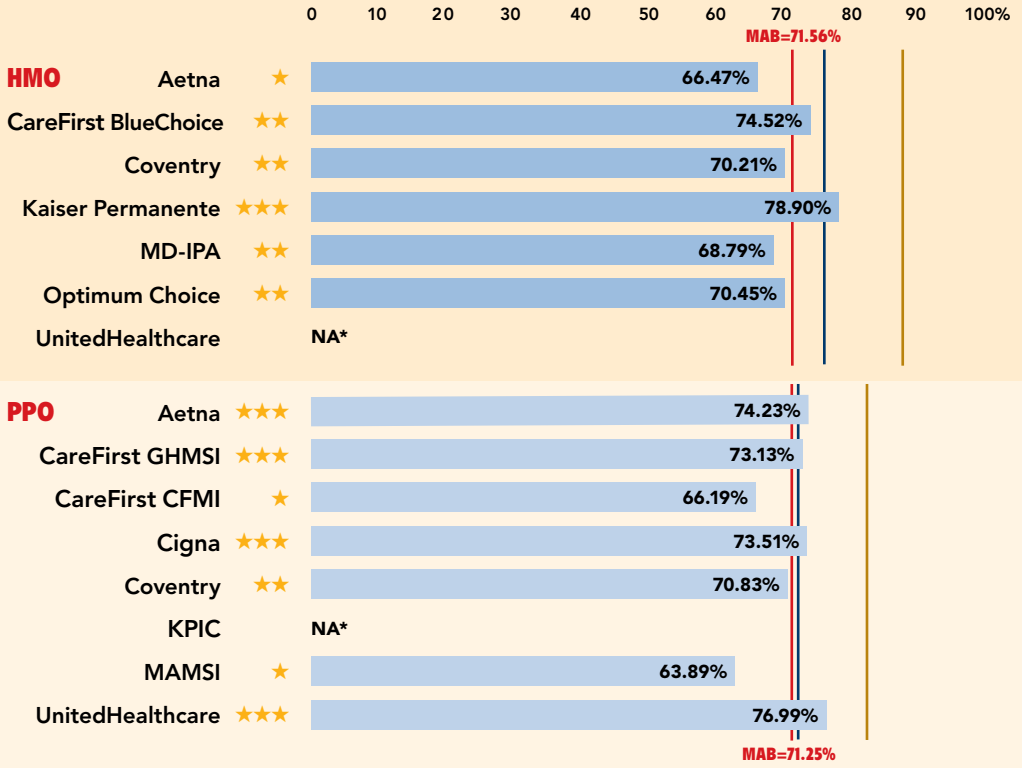
For this performance indicator, a higher percentage is better, which means that more members 6 years of age and over who were hospitalized for treatment of selected mental health disorders received timely follow-up within 30 days of discharge. This measure includes those members who also received timely follow-up within 7 days of discharge.

RATIONALE

It is important to provide regular follow-up therapy to patients after they have been hospitalized for mental illness. Outpatient visits with a behavioral health care provider that begin soon after discharge are recommended to make sure that the patient's transition to the home or work environment is supported and that gains made during hospitalization are not lost. It also helps behavioral health care providers to detect early post-hospitalization reactions or medication problems and provide appropriate interventions.

National Institute of Mental Health
National Institutes of Health

FOLLOW-UP WITHIN 30 DAYS – 6+ YEARS OF AGE



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PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

NA* Insufficient eligible members (fewer than 30) to calculate rate

Data Source: HEDIS® Submission or Health Benefit Plan Records

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

DESCRIPTION

Each health benefit plan reports on multiple indicators under this measure. Four separate indicators include:

1. Initiation of Alcohol and Other Drug (AOD) Treatment-Adolescents: The percentage of adolescents aged 13 to 17 years in 2013 with a new episode of AOD dependence, whose treatment was initiated through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis.

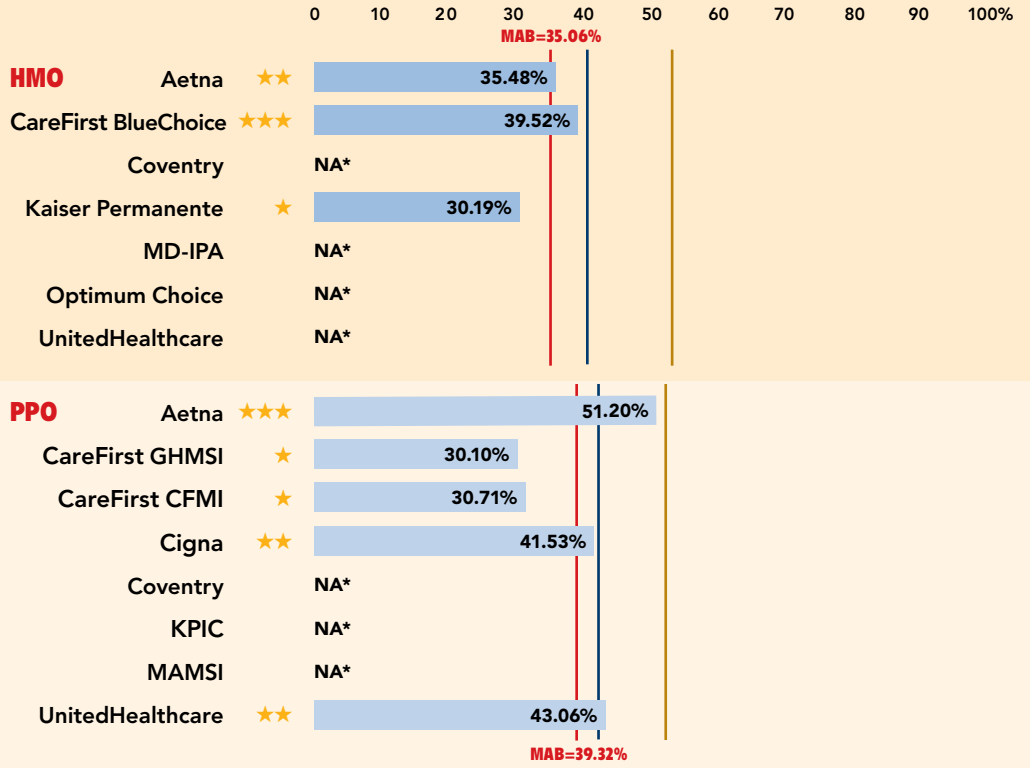
For this performance indicator, a higher percentage is better, which means that more adolescents 13 to 17 years of age who were diagnosed with AOD dependence received treatment within 14 days of diagnosis.

RATIONALE

"Substance use, including underage drinking and the non-medical use of prescription and over-the-counter medications, significantly affects the health and well-being of our nation's youth and people of all ages." In order to get the timely help they need, it is important for people with alcohol and other drug (AOD) disorders to overcome barriers to care such as the negative social stigma associated with AOD disorders and treatment, denial of the problem, as well as limited access to immediately available treatment services.

Substance Abuse and Mental Health Services Administration U.S. Department of Health and Human Services

INITIATION WITHIN 14 DAYS – 13 TO 17 YEARS OF AGE



More stars indicate better health benefit plan performance.

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PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

NA* Insufficient eligible members (fewer than 30) to calculate rate

Data Source: HEDIS® Submission or Health Benefit Plan Records

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment continued

DESCRIPTION

2. Initiation of Alcohol and Other Drug (AOD) Treatment-Adults: The percentage of adults aged 18 years and over in 2013 with a new episode of AOD dependence, whose treatment was initiated through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis.

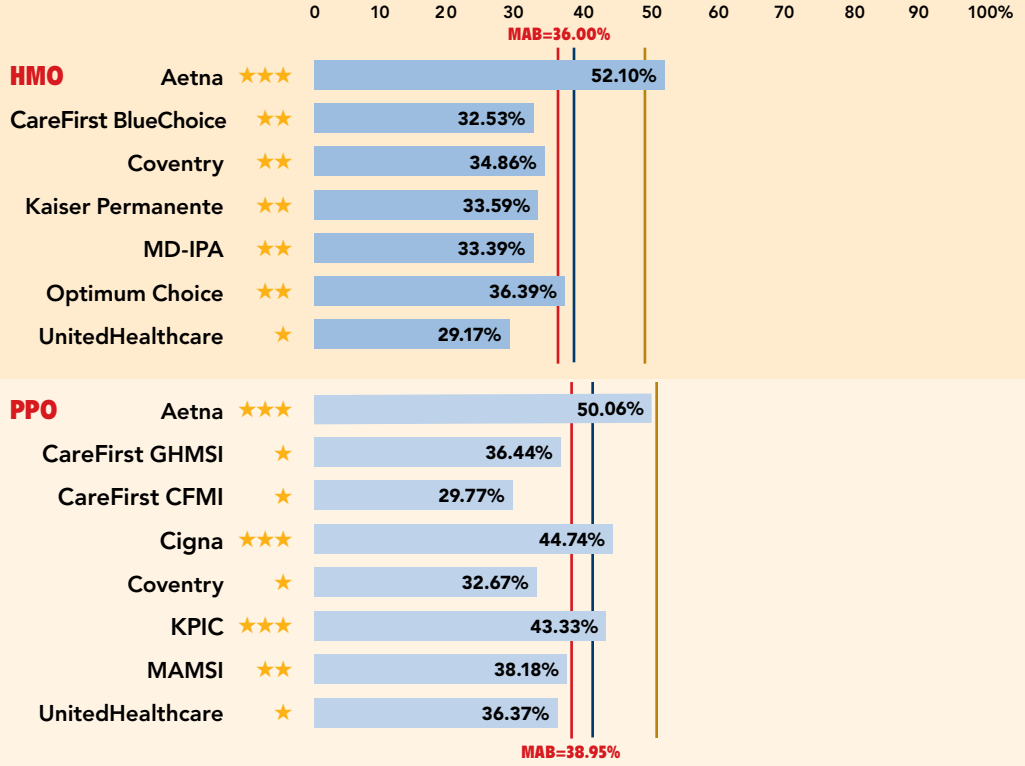
For this performance indicator, a higher percentage is better, which means that more adults 18 years of age and over who were diagnosed with AOD dependence received treatment within 14 days of diagnosis.

RATIONALE

"Substance use, including underage drinking and the non-medical use of prescription and over-the-counter medications, significantly affects the health and well-being of our nation's youth and people of all ages." In order to get the timely help they need, it is important for people with alcohol and other drug (AOD) disorders to overcome barriers to care such as the negative social stigma associated with AOD disorders and treatment, denial of the problem, as well as limited access to immediately available treatment services.

Substance Abuse and Mental Health Services Administration U.S. Department of Health and Human Services

INITIATION WITHIN 14 DAYS – 18+ YEARS OF AGE



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PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
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BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: HEDIS® Submission or Health Benefit Plan Records

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment continued

DESCRIPTION

3. Engagement of Alcohol and Other Drug (AOD) Treatment-Adolescents: The percentage of adolescents aged 13 to 17 years in 2013 with a new episode of AOD dependence, whose treatment was initiated through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis and who had two or more additional services within 30 days of the initiation visit.

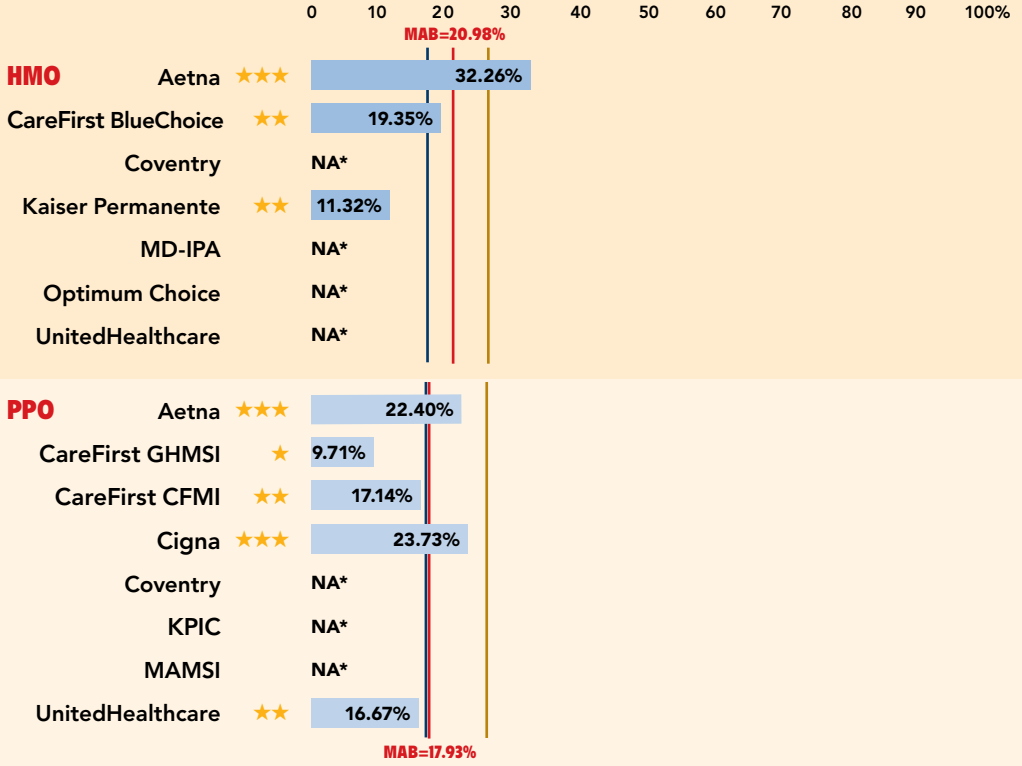
For this performance indicator, a higher percentage is better, which means that more adolescents 13 to 17 years of age who were diagnosed with AOD dependence received two or more additional follow-up treatments within 30 days of their initial visit.

RATIONALE

"Substance use, including underage drinking and the non-medical use of prescription and over-the-counter medications, significantly affects the health and well-being of our nation's youth and people of all ages." In order to get the timely help they need, it is important for people with alcohol and other drug (AOD) disorders to overcome barriers to care such as the negative social stigma associated with AOD disorders and treatment, denial of the problem, as well as limited access to immediately available treatment services.

Substance Abuse and Mental Health Services Administration U.S. Department of Health and Human Services

ENGAGEMENT WITHIN 30 DAYS – 13 TO 17 YEARS OF AGE



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PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

NA* Insufficient eligible members to calculate rate

Data Source: HEDIS® Submission or Health Benefit Plan Records

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment continued

DESCRIPTION

4. Engagement of Alcohol and Other Drug (AOD) Treatment-Adults: The percentage of adults aged 18 years and over in 2013 with a new episode of AOD dependence, whose treatment was initiated through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis and who had two or more additional services within 30 days of the initiation visit.

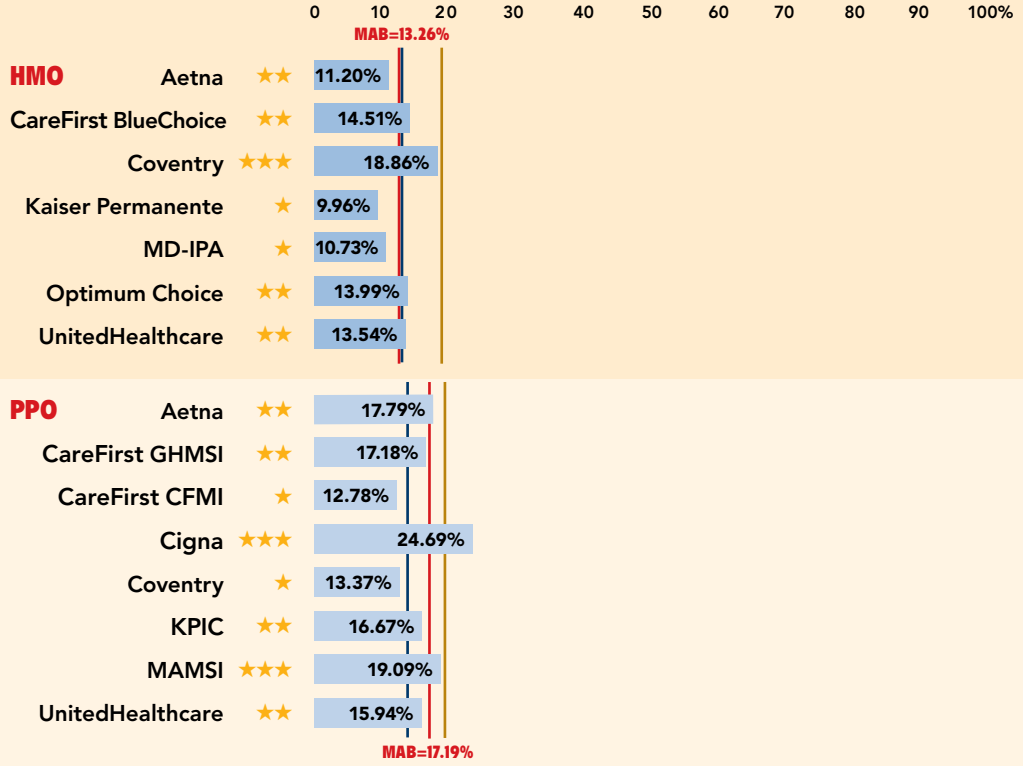
For this performance indicator, a higher percentage is better, which means that more adults 18 years of age and over who were diagnosed with AOD dependence received two or more additional follow-up treatments within 30 days of their initial visit.

RATIONALE

"Substance use, including underage drinking and the non-medical use of prescription and over-the-counter medications, significantly affects the health and well-being of our nation's youth and people of all ages." In order to get the timely help they need, it is important for people with alcohol and other drug (AOD) disorders to overcome barriers to care such as the negative social stigma associated with AOD disorders and treatment, denial of the problem, as well as limited access to immediately available treatment services.

Substance Abuse and Mental Health Services Administration U.S. Department of Health and Human Services

ENGAGEMENT WITHIN 30 DAYS – 18+ YEARS OF AGE



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PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: HEDIS® Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Member Experience and Satisfaction with Health Benefit Plan

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey program is trademarked and overseen by the United States Department of Health and Human Services – Agency For Healthcare Research and Quality (AHRQ). Maryland Health Care Commission has implemented use of the CAHPS® 5.0H, Adult Health Plan Survey as part of the Health Benefit Plan Quality and Performance Evaluation System. The CAHPS® Surveys each include a myriad of survey questions designed to capture health benefit plan member perspectives on health care quality.

Aspirin Discussion

DESCRIPTION

The percentage of adults in the target population who discussed the risks and benefits of using aspirin with a doctor or other health provider. A single rate is reported for the target population below:

- Women aged 56 to 79 years, regardless of risk factors
- Men aged 46 to 79 years, regardless of risk factors

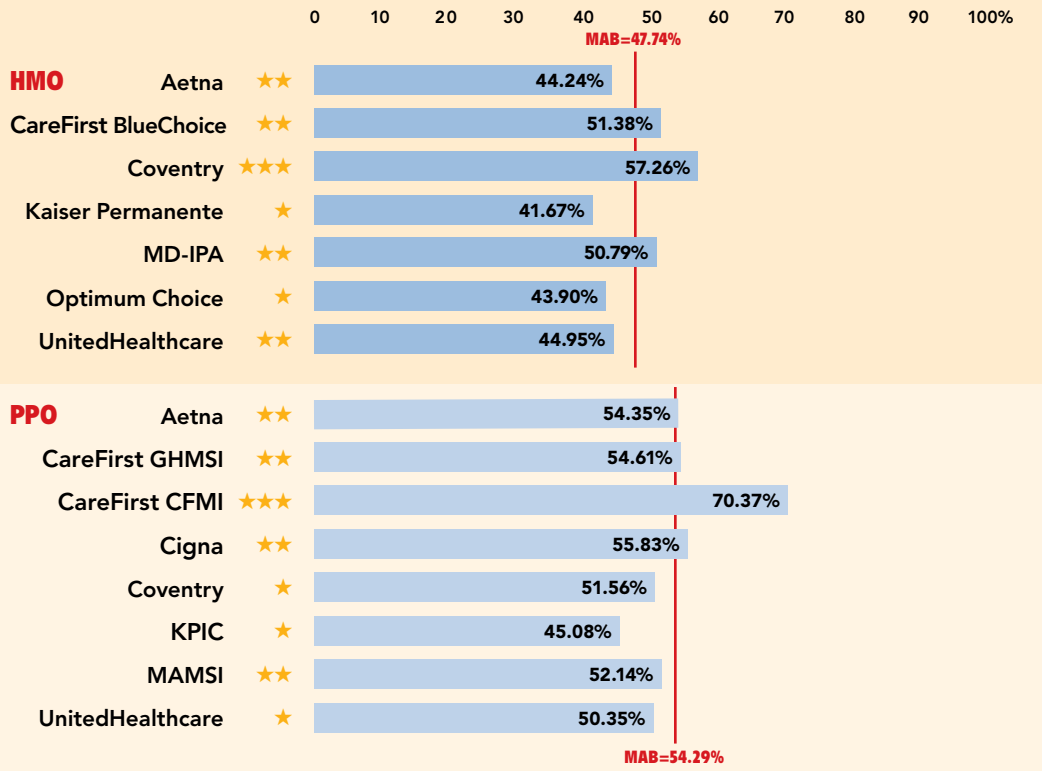
For this measure, a higher percentage is better, which means more adults in the target population did discuss the risks and benefits of using aspirin as part of their treatment regimen.

RATIONALE

The United States Preventive Services Task Force recommends that health care providers discuss the use of aspirin therapy when a net benefit is present for men, to prevent heart attacks, and for women, to prevent strokes. "A net benefit means that the potential benefit from taking aspirin outweighs the harms, mainly gastrointestinal (GI) bleeding." Discussions with patients should address both the potential benefits and harms of aspirin therapy.

Using Aspirin for the Primary Prevention of Cardiovascular Disease: Clinician Fact Sheet, June 2009
Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services

ASPIRIN DISCUSSION – WOMEN 56 TO 79 AND MEN 46 TO 79 YEARS OF AGE



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PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE) – National benchmark not available
NTP (NATIONAL TOP PERFORMERS) – National benchmark not available

Data Source: HEDIS® Submission or Health Benefit Plan Records

Flu Vaccinations for Adults

DESCRIPTION

The percentage of surveyed adults aged 18 to 64 years who received an influenza vaccination (Flu shot) between July 1 of the 2013 measurement year and the date when the CAHPS® 5.0H Commercial Adult survey was completed.

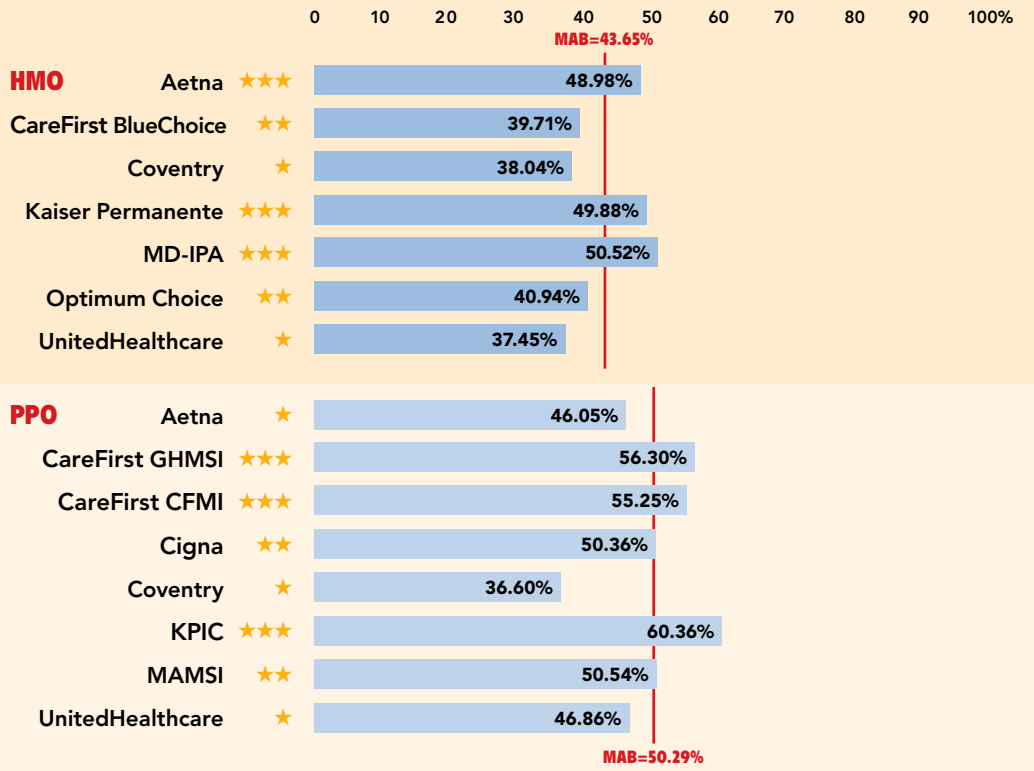
For this measure, a higher percentage is better, which means that more adults 18 to 64 years of age did receive an annual Flu shot after July 1 of the 2013 measurement year.

RATIONALE

Influenza (the Flu) infections result in significant health care expenditures each year, and the vaccine to prevent the Flu is safe and effective. Since 2010, the Centers for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP) have recommended that everyone six months of age and over receive yearly influenza vaccinations, with few exceptions. Healthy people in any age group and even those without any high-risk conditions can benefit from getting their annual Flu shot, as they can experience a reduced number of illnesses, physician visits, missed work/school days, and reduced disease transmission, especially to loved ones who may be at a higher risk of getting infected.

Media Statement,
June 25, 2014
Centers for Disease Control and Prevention

FLU SHOTS – 18 TO 64 YEARS OF AGE



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BENCHMARKS

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NAB (NATIONAL AVERAGE) – National benchmark not available
NTP (NATIONAL TOP PERFORMERS) – National benchmark not available

Data Source: HEDIS® Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

MEMBER EXPERIENCE AND SATISFACTION WITH HEALTH BENEFIT PLAN

Call Answer Timeliness

DESCRIPTION

The percentage of calls received by the organization's Member Services call centers during operating hours in 2013 that were answered by a live voice within 30 seconds.

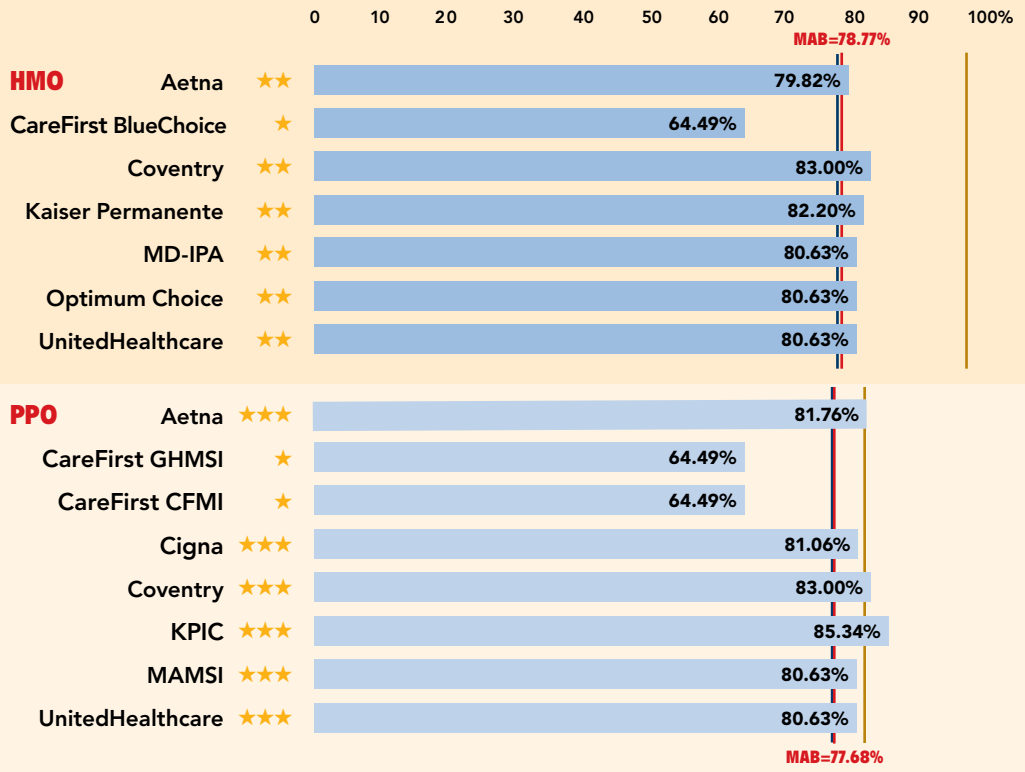
For this measure, a higher percentage is better, which means more members' calls to the organization's Member Services call centers were timely answered by a live voice within 30 seconds.

RATIONALE

Customer service continues to gain importance as health benefit plan members and employers demand improvements in the health care experience. A member's ability to reach out to a health benefit plan through their customer service call center and talk to a live person in a timely manner is the first step toward ensuring that the health benefit plan is meeting the needs of their customers. High performance on this measure by a carrier's health benefit plan(s) should improve health benefit plan member satisfaction.

National Quality Measures Clearinghouse
National Committee for Quality Assurance Health Care Effectiveness Data and Information Set (HEDIS®) 2014
Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services

CALL ANSWERED WITHIN 30 SECONDS – BY A LIVE VOICE



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BENCHMARKS

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NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: HEDIS® Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

MEMBER EXPERIENCE AND SATISFACTION WITH HEALTH BENEFIT PLAN

Getting Needed Care

DESCRIPTION

A composite measure that assesses member experiences with getting needed care. The composite score represents the percentage of survey participants who responded with "Usually" or "Always" for the following two related questions:

- **Q1.** In the last 12 months, how often was it easy to get the care, tests, or treatment you needed?
- **Q2.** In the last 12 months, how often did you get an appointment to see a specialist as soon as you needed?

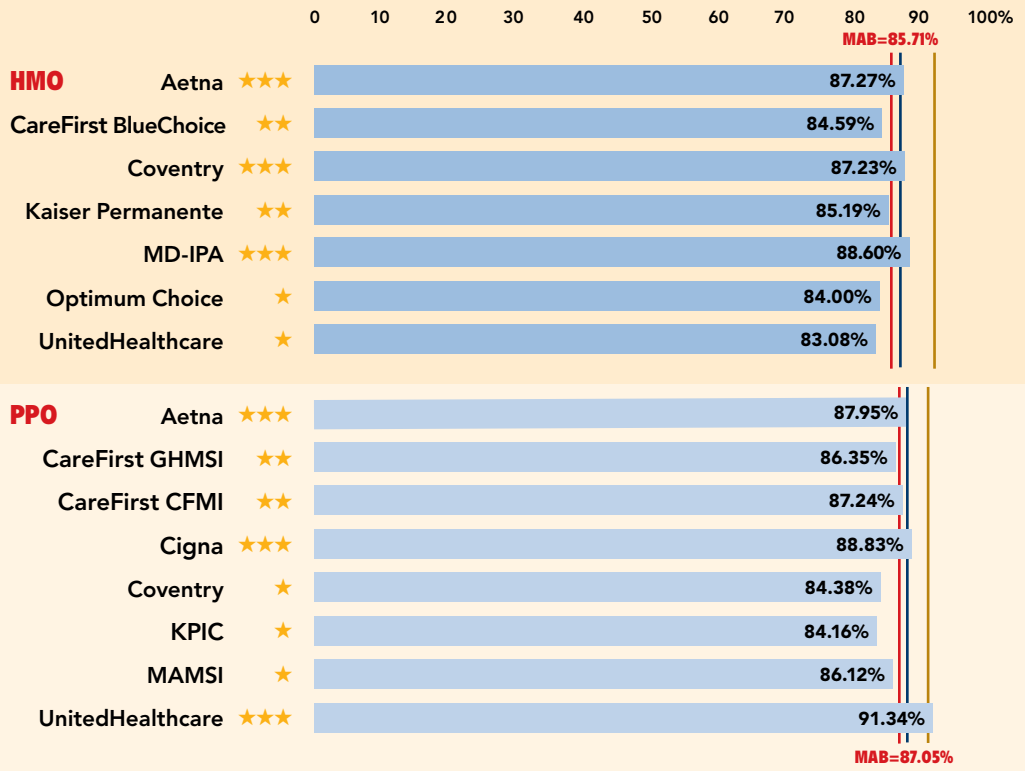
For this measure, a higher percentage is better and represents the proportion of survey respondents who feel they usually or always got the care they needed.

RATIONALE

The CAHPS® 5.0H Adult Health Plan Survey is a national survey designed to capture valuable information from consumers about their experiences with health care through their health benefit plan. The survey includes a core set of questions, with some questions grouped into composite areas of health care. A few additional questions were included for health benefit plans operating in the State of Maryland. Survey results give health benefit plans the opportunity for continuous improvement in member care.

Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services

GETTING NEEDED CARE



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PERFORMANCE RATING

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BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: CAHPS® Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

MEMBER EXPERIENCE AND SATISFACTION WITH HEALTH BENEFIT PLAN

Getting Care Quickly

DESCRIPTION

A composite measure that assesses member experiences with getting care quickly. The composite score represents the percentage of survey participants who responded with "Usually" or "Always" for the following two related questions:

- **Q1.** In the last 12 months, when you needed care right away, how often did you get care as soon as you needed?
- **Q2.** In the last 12 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?

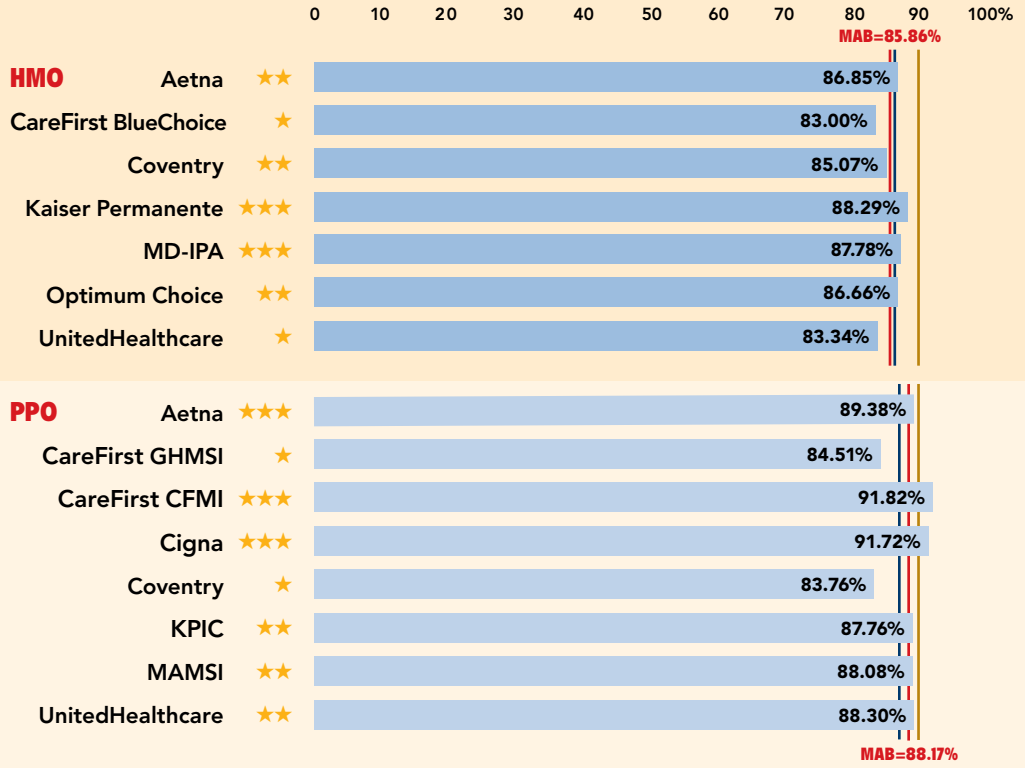
For this measure, a higher percentage is better and represents the proportion of survey respondents who feel they usually or always got care quickly.

RATIONALE

The CAHPS® 5.0H Adult Health Plan Survey is a national survey designed to capture valuable information from consumers about their experiences with health care through their health benefit plan. The survey includes a core set of questions, with some questions grouped into composite areas of health care. A few additional questions were included for health benefit plans operating in the State of Maryland. Survey results give health benefit plans the opportunity for continuous improvement in member care.

Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services

GETTING CARE QUICKLY



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PERFORMANCE RATING

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BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: CAHPS® Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

MEMBER EXPERIENCE AND SATISFACTION WITH HEALTH BENEFIT PLAN

How Well Doctors Communicate

DESCRIPTION

A composite measure that assesses member experiences with how well doctors communicate. The composite score represents the percentage of survey participants who responded with "Usually" or "Always" for the following four related questions:

- **Q1.** In the last 12 months, how often did your personal doctor explain things in a way that was easy to understand?
- **Q2.** In the last 12 months, how often did your personal doctor listen carefully to you?
- **Q3.** In the last 12 months, how often did your personal doctor show respect for what you had to say?
- **Q4.** In the last 12 months, how often did your personal doctor spend enough time with you?

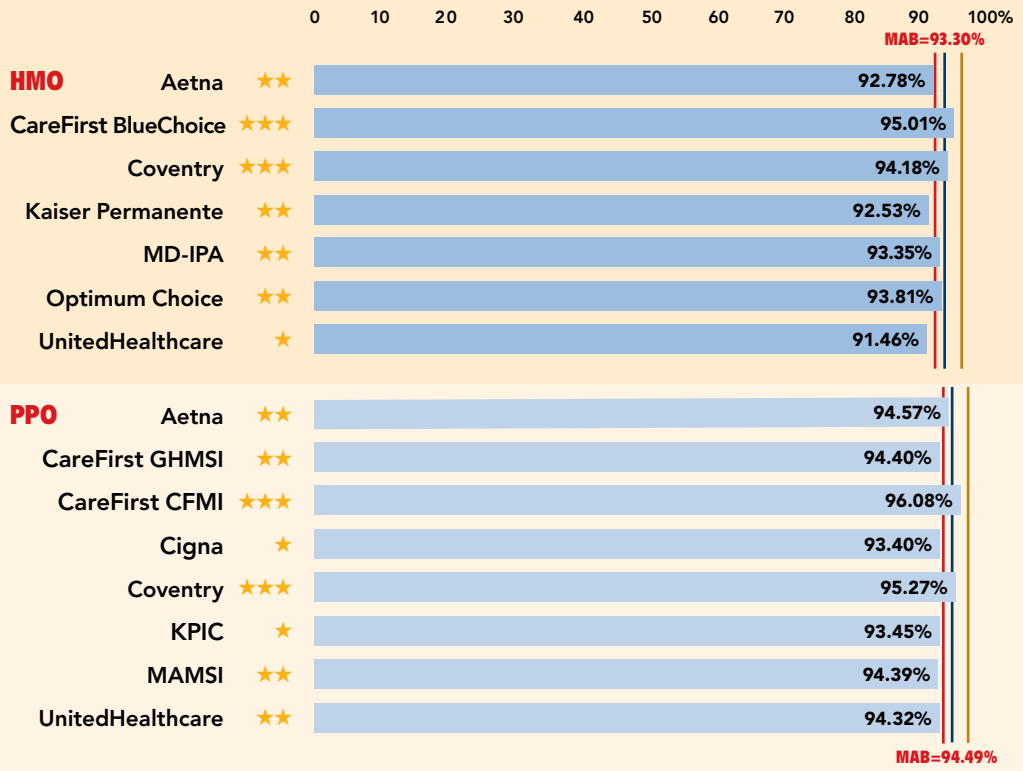
For this measure, a higher percentage is better and represents the proportion of survey respondents who feel their personal doctor usually or always communicated well.

RATIONALE

The CAHPS® 5.0H Adult Health Plan Survey is a national survey designed to capture valuable information from consumers about their experiences with health care through their health benefit plan. The survey includes a core set of questions, with some questions grouped into composite areas of health care. A few additional questions were included for health benefit plans operating in the State of Maryland. Survey results give health benefit plans the opportunity for continuous improvement in member care.

Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services

HOW WELL DOCTORS COMMUNICATE



More stars indicate better health benefit plan performance.

The "stars" represent the relative comparisons between the health benefit plans and the Maryland Average Benchmark.

PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: CAHPS® Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

MEMBER EXPERIENCE AND SATISFACTION WITH HEALTH BENEFIT PLAN

Customer Service

DESCRIPTION

A composite measure that assesses member experiences with customer service. The composite score represents the percentage of survey participants who responded with "Usually" or "Always" for the following two related questions:

- **Q1.** In the last 12 months, how often did your health plan's customer service staff give you the information or help you needed?
- **Q2.** In the last 12 months, how often did your health plan's customer service staff treat you with courtesy and respect?

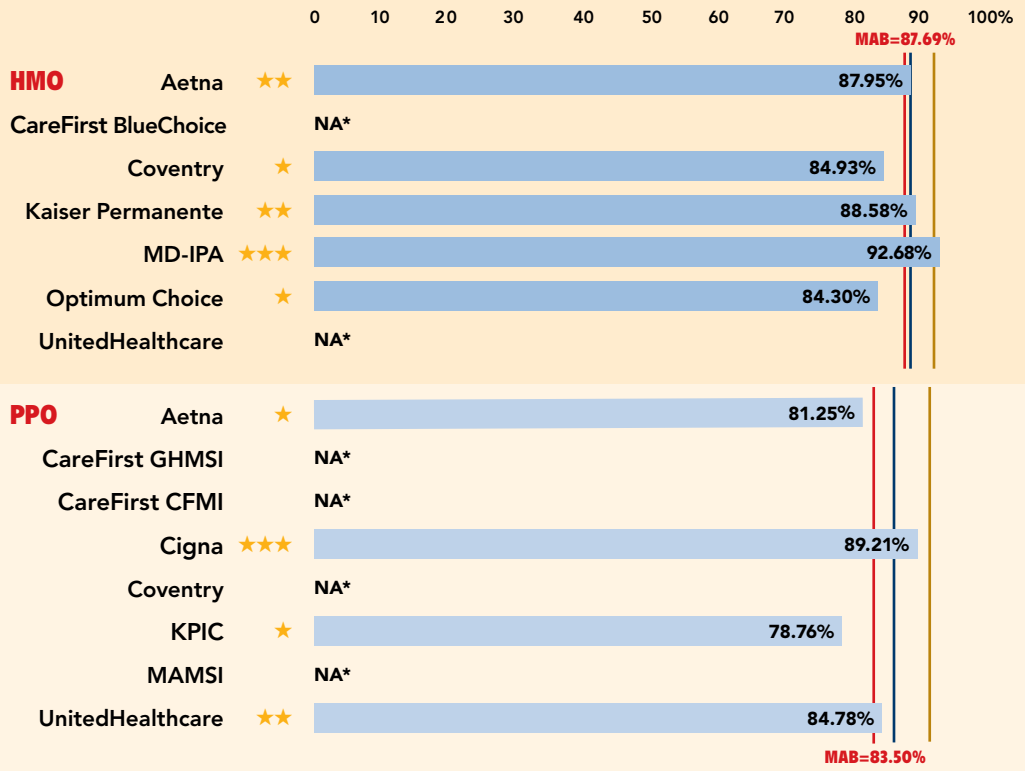
For this measure, a higher percentage is better and represents the proportion of survey respondents who feel they usually or always had a positive interaction with customer service.

RATIONALE

The CAHPS® 5.0H Adult Health Plan Survey is a national survey designed to capture valuable information from consumers about their experiences with health care through their health benefit plan. The survey includes a core set of questions, with some questions grouped into composite areas of health care. A few additional questions were included for health benefit plans operating in the State of Maryland. Survey results give health benefit plans the opportunity for continuous improvement in member care.

Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services

CUSTOMER SERVICE



More stars indicate better health benefit plan performance.

The "stars" represent the relative comparisons between the health benefit plans and the Maryland Average Benchmark.

PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

NA* Insufficient responses (fewer than 100) to calculate a rate

Data Source: CAHPS® Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

MEMBER EXPERIENCE AND SATISFACTION WITH HEALTH BENEFIT PLAN

Claims Processing

DESCRIPTION

A composite measure that assesses member experiences with claims processing. The composite score represents the percentage of survey participants who responded with "Usually" or "Always" for the following two related questions:

- **Q1.** In the last 12 months, how often did your health plan handle your claims quickly?
- **Q2.** In the last 12 months, how often did your health plan handle your claims correctly?

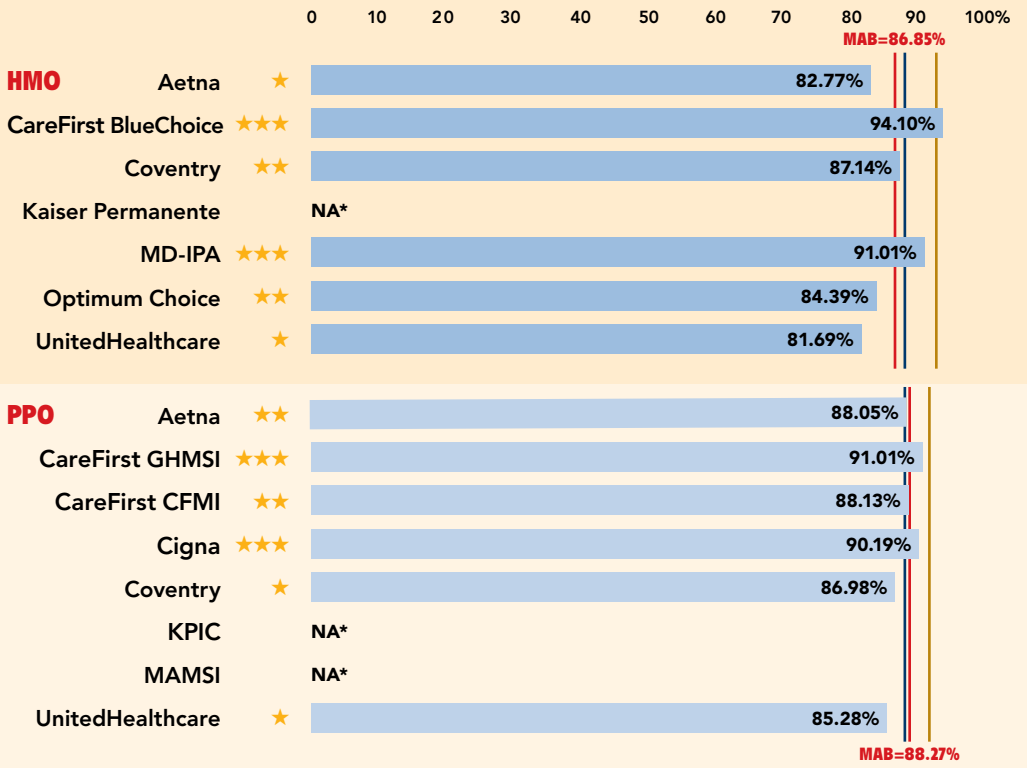
For this measure, a higher percentage is better and represents the proportion of survey respondents who feel they usually or always had a positive interaction with claims processing.

RATIONALE

The CAHPS® 5.0H Adult Health Plan Survey is a national survey designed to capture valuable information from consumers about their experiences with health care through their health benefit plan. The survey includes a core set of questions, with some questions grouped into composite areas of health care. A few additional questions were included for health benefit plans operating in the State of Maryland. Survey results give health benefit plans the opportunity for continuous improvement in member care.

Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services

CLAIMS PROCESSING



More stars indicate better health benefit plan performance.

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PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

NA* Insufficient responses (fewer than 100) to calculate a rate

Data Source: CAHPS® Submission or Health Benefit Plan Records

Shared Decision Making

DESCRIPTION

A composite measure that assesses member experiences with shared decision making. The composite score represents the percentage of survey participants who responded with "Yes, Some" or "Yes, A lot" for the following three related questions:

- **Q1.** When you talked about starting or stopping a prescription medicine, how much did a doctor or other health provider talk about the reasons you might want to take a medicine?
- **Q2.** When you talked about starting or stopping a prescription medicine, how much did a doctor or other health provider talk about the reasons you might not want to take a medicine?
- **Q3.** When you talked about starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for you?

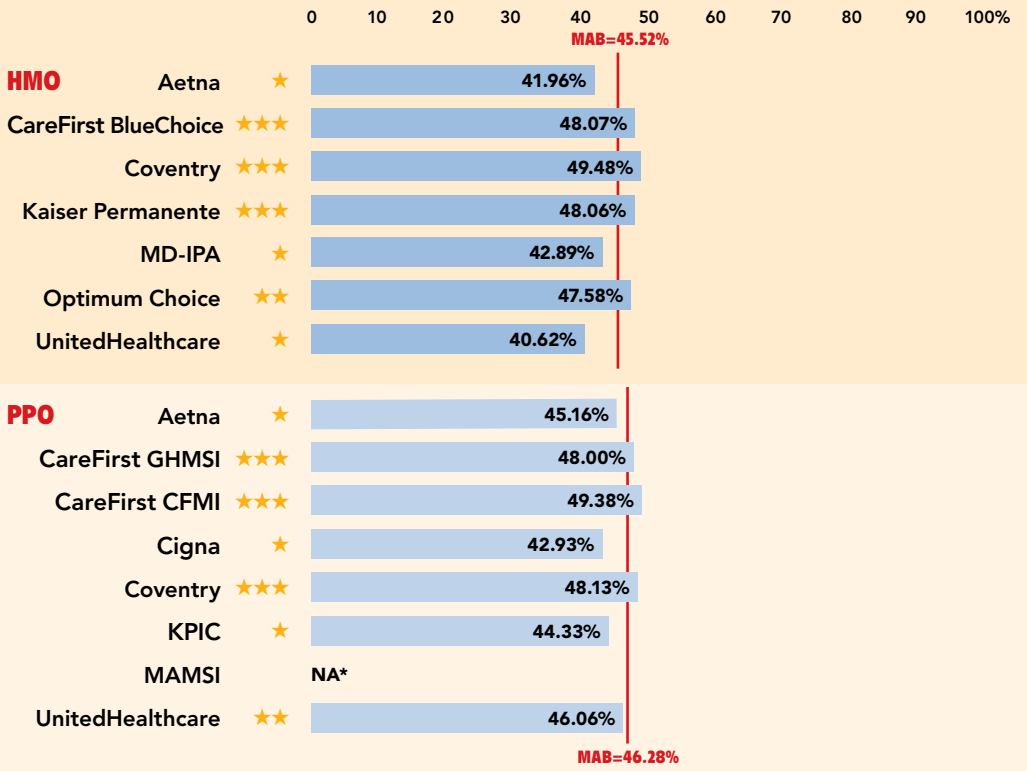
For this measure, a higher percentage is better and represents the proportion of survey respondents who feel they had a role in the decision making process with their doctor or other health provider.

RATIONALE

The CAHPS® 5.0H Adult Health Plan Survey is a national survey designed to capture valuable information from consumers about their experiences with health care through their health benefit plan. The survey includes a core set of questions, with some questions grouped into composite areas of health care. A few additional questions were included for health benefit plans operating in the State of Maryland. Survey results give health benefit plans the opportunity for continuous improvement in member care.

Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services

SHARED DECISION MAKING



More stars indicate better health benefit plan performance.

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PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE) – National benchmark not available
NTP (NATIONAL TOP PERFORMERS) – National benchmark not available

NA* Insufficient responses (fewer than 100) to calculate a rate

Data Source: CAHPS® Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

MEMBER EXPERIENCE AND SATISFACTION WITH HEALTH BENEFIT PLAN

Plan Information on Costs

DESCRIPTION

A composite measure that assesses member experiences with plan information on costs. The composite score represents the percentage of survey participants who responded with "Usually" or "Always" for the following two related questions:

- **Q1.** In the last 12 months, how often were you able to find out from your health plan how much you would have to pay for a health care service or equipment?
- **Q2.** In the last 12 months, how often were you able to find out from your health plan how much you would have to pay for specific prescription medicines?

For this measure, a higher percentage is better and represents the proportion of survey respondents who feel they usually or always were able to find information from their plan on costs.

RATIONALE

The CAHPS® 5.0H Adult Health Plan Survey is a national survey designed to capture valuable information from consumers about their experiences with health care through their health benefit plan. The survey includes a core set of questions, with some questions grouped into composite areas of health care. A few additional questions were included for health benefit plans operating in the State of Maryland. Survey results give health benefit plans the opportunity for continuous improvement in member care.

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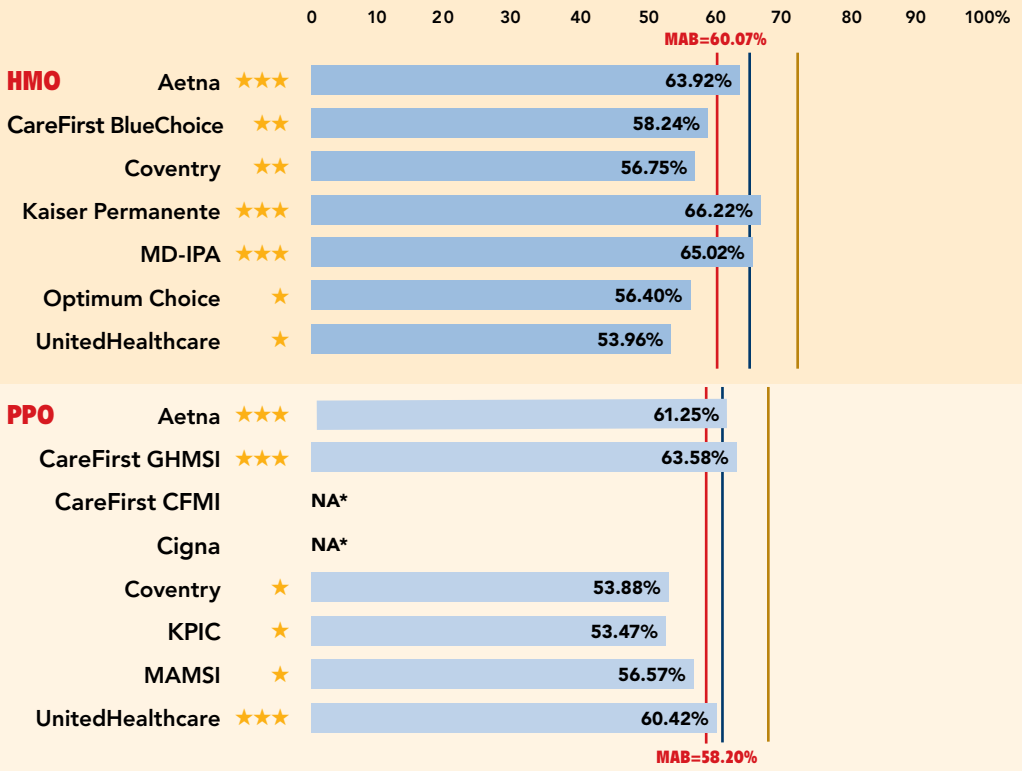
U.S. Department of Health and Human Services

PLAN INFORMATION ON COSTS



More stars indicate better health benefit plan performance.

The "stars" represent the relative comparisons between the health benefit plans and the Maryland Average Benchmark.

PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

NA* Insufficient responses (fewer than 100) to calculate a rate

Data Source: CAHPS® Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

MEMBER EXPERIENCE AND SATISFACTION WITH HEALTH BENEFIT PLAN

Health Promotion and Education

DESCRIPTION

A standard measure that assesses member experiences with health promotion and education. The standard score represents the percentage of survey participants who responded with "Yes" for the following question:

- **Q1.** In the last 12 months, did you and a doctor or other health provider talk about specific things you could do to prevent illness?

For this measure, a higher percentage is better and represents the proportion of survey respondents who spoke with their doctor or other health provider about preventative care.

RATIONALE

The CAHPS® 5.0H Adult Health Plan Survey is a national survey designed to capture valuable information from consumers about their experiences with health care through their health benefit plan. The survey includes a core set of questions, with some questions grouped into composite areas of health care. A few additional questions were included for health benefit plans operating in the State of Maryland. Survey results give health benefit plans the opportunity for continuous improvement in member care.

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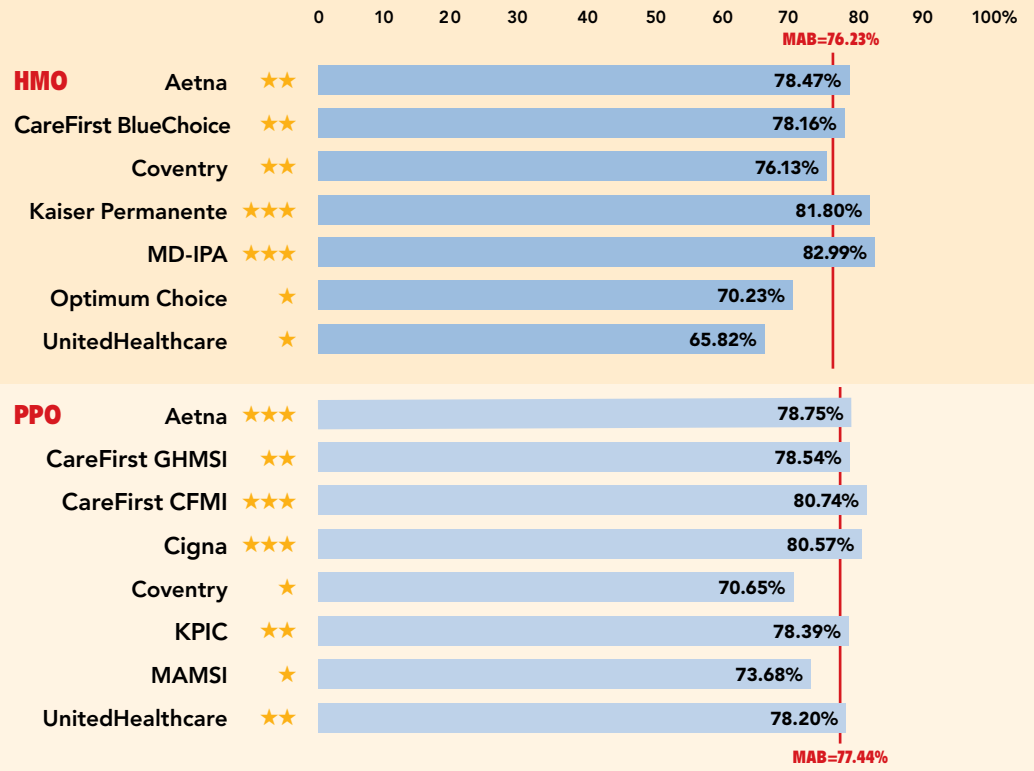
U.S. Department of Health and Human Services

HEALTH PROMOTION AND EDUCATION



More stars indicate better health benefit plan performance.

The "stars" represent the relative comparisons between the health benefit plans and the Maryland Average Benchmark.

PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE) – National benchmark not available
NTP (NATIONAL TOP PERFORMERS) – National benchmark not available

Data Source: CAHPS® Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

MEMBER EXPERIENCE AND SATISFACTION WITH HEALTH BENEFIT PLAN

Coordination of Care

DESCRIPTION

A standard measure that assesses member experiences with coordination of care. The standard score represents the percentage of survey participants who responded with "Usually" or "Always" for the following question:

- **Q1.** In the last 12 months, how often did your personal doctor seem informed and up-to-date about the care you got from these [other] doctors or other health providers?

For this measure, a higher percentage is better and represents the proportion of survey respondents who feel their doctor coordinated care with other doctors or health providers.

RATIONALE

The CAHPS® 5.0H Adult Health Plan Survey is a national survey designed to capture valuable information from consumers about their experiences with health care through their health benefit plan. The survey includes a core set of questions, with some questions grouped into composite areas of health care. A few additional questions were included for health benefit plans operating in the State of Maryland. Survey results give health benefit plans the opportunity for continuous improvement in member care.

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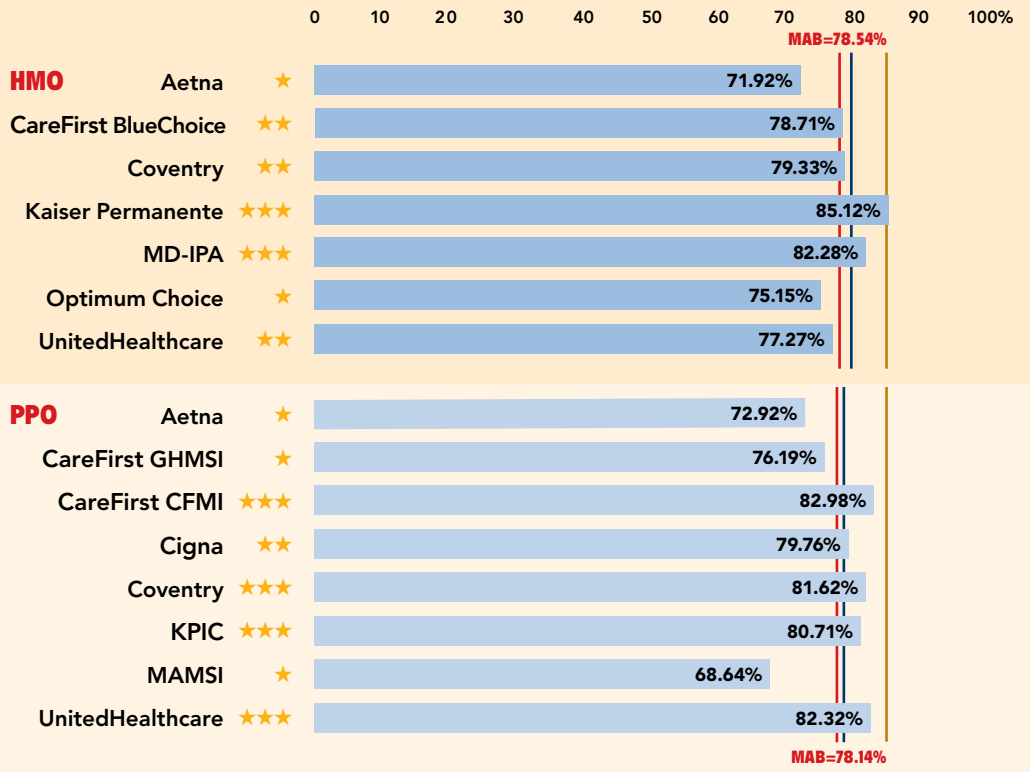
U.S. Department of Health and Human Services

COORDINATION OF CARE



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The "stars" represent the relative comparisons between the health benefit plans and the Maryland Average Benchmark.

PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: CAHPS® Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

MEMBER EXPERIENCE AND SATISFACTION WITH HEALTH BENEFIT PLAN

Rating of All Health Care

DESCRIPTION

A standard measure that assesses member experiences with and rating of all health care. The standard score represents the percentage of survey participants who rated their health care an 8, 9 or 10 on a scale of 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible.

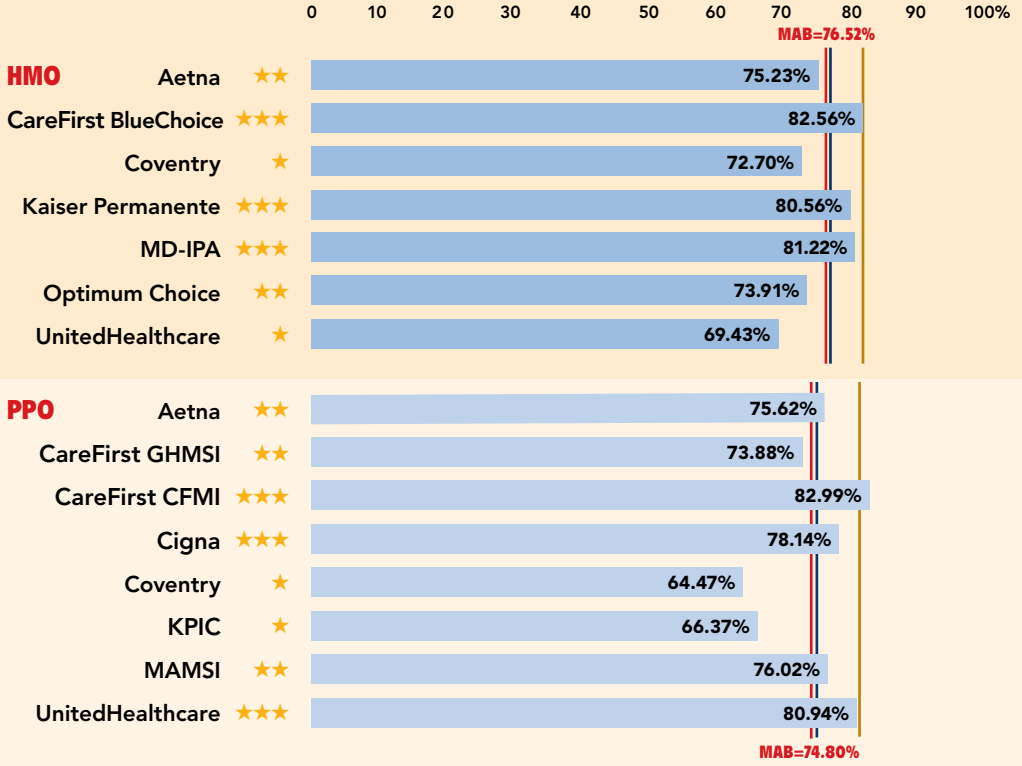
For this measure, a higher percentage is better and represents the proportion of survey respondents who feel the health care they receive is good overall.

RATIONALE

The CAHPS® 5.0H Adult Health Plan Survey is a national survey designed to capture valuable information from consumers about their experiences with health care through their health benefit plan. The survey includes a core set of questions, with some questions grouped into composite areas of health care. A few additional questions were included for health benefit plans operating in the State of Maryland. Survey results give health benefit plans the opportunity for continuous improvement in member care.

Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services

GOOD OVERALL RATING OF ALL HEALTH CARE



More stars indicate better health benefit plan performance.

The "stars" represent the relative comparisons between the health benefit plans and the Maryland Average Benchmark.

PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: CAHPS® Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

MEMBER EXPERIENCE AND SATISFACTION WITH HEALTH BENEFIT PLAN

Rating of Personal Doctor

DESCRIPTION

A standard measure that assesses member experiences with and rating of their personal doctor. The standard score represents the percentage of survey participants who rated their personal doctor an 8, 9 or 10 on a scale of 0 to 10, where 0 is the worst doctor possible and 10 is the best doctor possible.

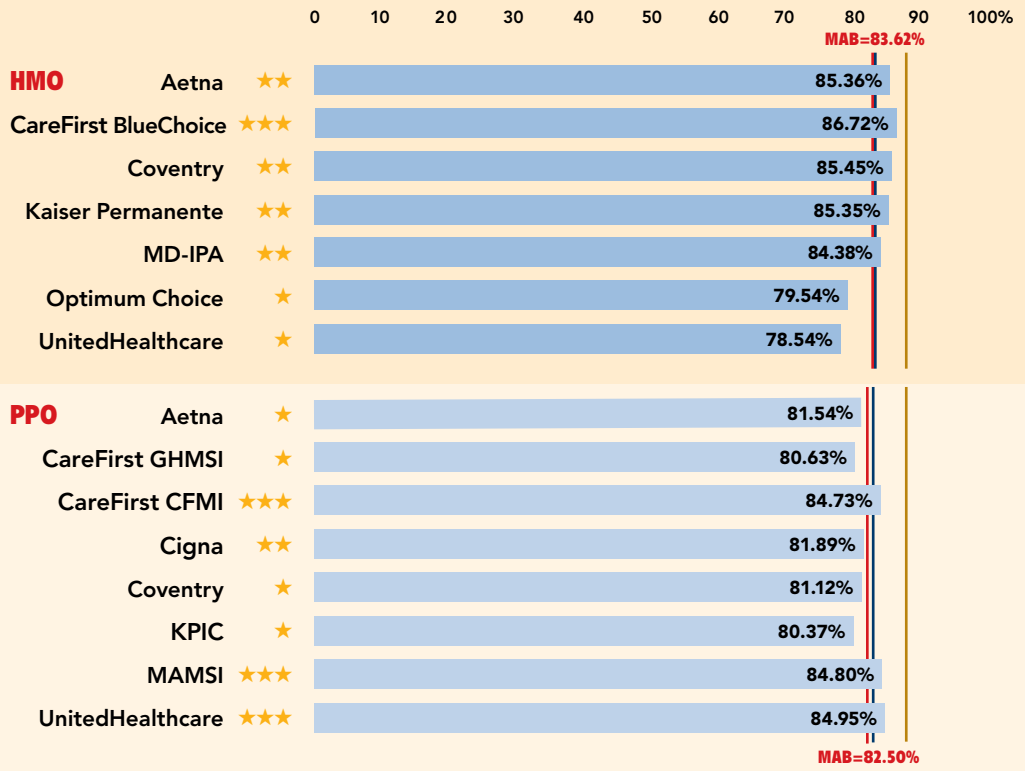
For this measure, a higher percentage is better and represents the proportion of survey respondents who feel the care they receive from their personal doctor is good overall.

RATIONALE

The CAHPS® 5.0H Adult Health Plan Survey is a national survey designed to capture valuable information from consumers about their experiences with health care through their health benefit plan. The survey includes a core set of questions, with some questions grouped into composite areas of health care. A few additional questions were included for health benefit plans operating in the State of Maryland. Survey results give health benefit plans the opportunity for continuous improvement in member care.

Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services

GOOD OVERALL RATING OF PERSONAL DOCTOR



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PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: CAHPS® Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

MEMBER EXPERIENCE AND SATISFACTION WITH HEALTH BENEFIT PLAN

Rating of Specialist Seen Most Often

DESCRIPTION

A standard measure that assesses member experiences with and rating of their specialist seen most often. The standard score represents the percentage of survey participants who rated their specialist seen most often an 8, 9 or 10 on a scale from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible.

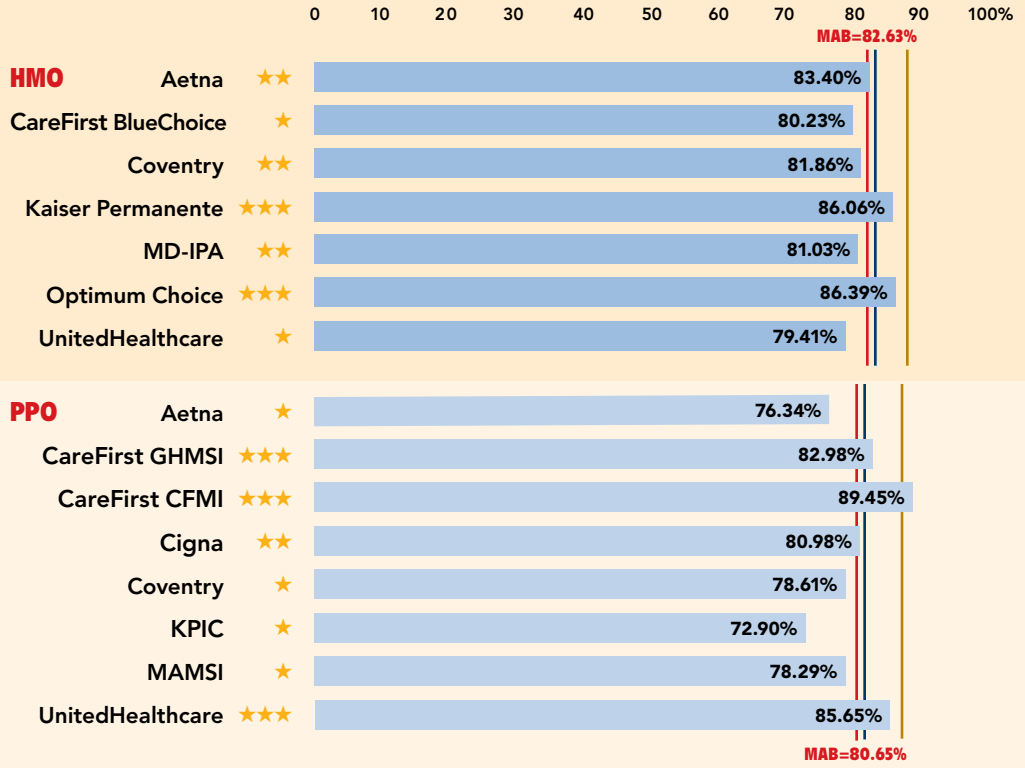
For this measure, a higher percentage is better and represents the proportion of survey respondents who feel the care they receive from their specialist is good overall.

RATIONALE

The CAHPS® 5.0H Adult Health Plan Survey is a national survey designed to capture valuable information from consumers about their experiences with health care through their health benefit plan. The survey includes a core set of questions, with some questions grouped into composite areas of health care. A few additional questions were included for health benefit plans operating in the State of Maryland. Survey results give health benefit plans the opportunity for continuous improvement in member care.

Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services

GOOD OVERALL RATING OF SPECIALIST SEEN MOST OFTEN



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PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB (MARYLAND AVERAGE)
NAB (NATIONAL AVERAGE)
NTP (NATIONAL TOP PERFORMERS)

Data Source: CAHPS® Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

MEMBER EXPERIENCE AND SATISFACTION WITH HEALTH BENEFIT PLAN

Rating of Health Benefit Plan

DESCRIPTION

A standard measure that assesses member experiences with and rating of their health benefit plan. The standard score represents the percentage of survey participants who rated their health benefit plan an 8, 9, or 10 on a scale from 0 to 10, where 0 is the worst health benefit plan possible and 10 is the best health benefit plan possible.

For this measure, a higher percentage is better and represents the proportion of survey respondents who feel the care they receive through their health benefit plan is good overall.

RATIONALE

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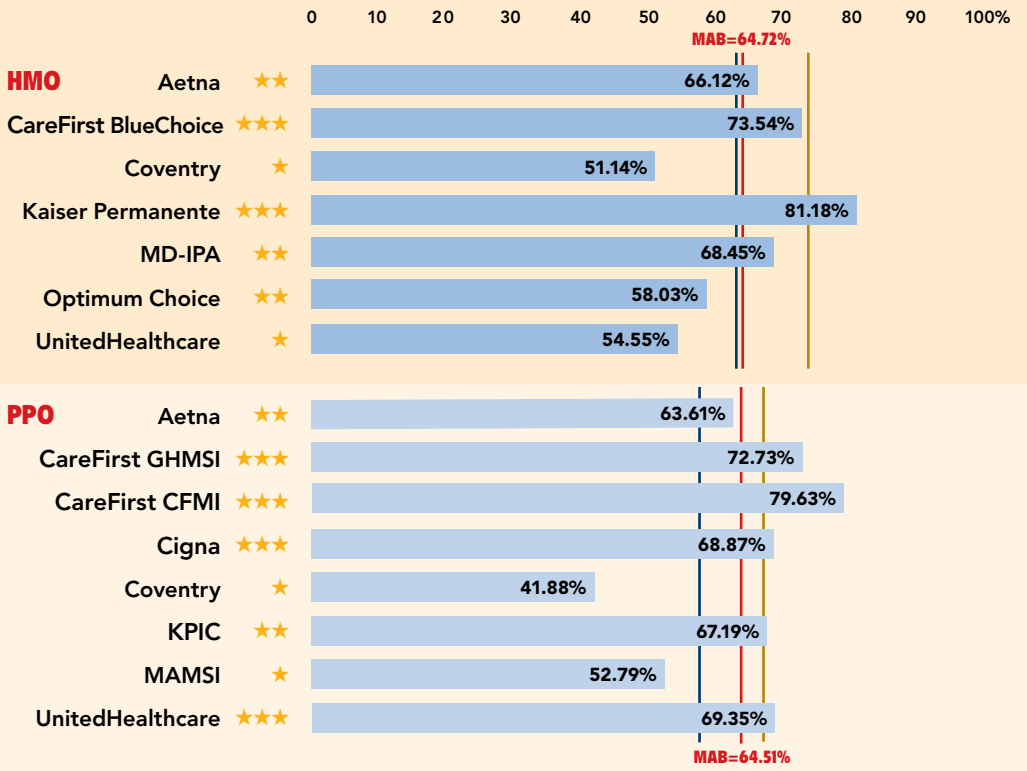
Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services

GOOD OVERALL RATING OF HEALTH BENEFIT PLAN



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PERFORMANCE RATING

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BENCHMARKS

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Data Source: CAHPS® Submission or Health Benefit Plan Records

IV. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

MEMBER EXPERIENCE AND SATISFACTION WITH HEALTH BENEFIT PLAN

MHCC Supplemental Questions and Answers															
Question	HMO							PPO							
	Aetna	CareFirst BlueChoice	Coventry	Kaiser Permanente	MD-IPA	Optimum Choice	United-Healthcare	Aetna	CareFirst GHMSI	CareFirst CFMI	Cigna	Coventry	KPIC	MAMSI	United-Healthcare
Finding A Personal Doctor															
With the choices provided by your health plan, how much of a problem, if any, was it to find a personal doctor in your plan with an office that is conveniently located? **RESPONSE USED: Not a Problem**	Maryland Average 87%							Maryland Average 85%							
	86%	89%	88%	90%	85%	86%	88%	88%	86%	88%	85%	81%	78%	89%	86%
Doctors are Polite and Considerate															
In the last 12 months, how often did your personal doctor talk too fast when talking with you? **RESPONSE USED: Never**	Maryland Average 84%							Maryland Average 85%							
	83%	85%	86%	87%	84%	84%	81%	84%	84%	91%	85%	84%	83%	88%	82%
In the last 12 months, how often did your personal doctor interrupt you when you were talking? **RESPONSE USED: Never**	Maryland Average 88%							Maryland Average 89%							
	87%	89%	90%	91%	85%	90%	84%	88%	84%	93%	85%	92%	91%	89%	87%
In the last 12 months, how often did your personal doctor use a condescending, sarcastic, or rude tone or manner with you? **RESPONSE USED: Never**	Maryland Average 96%							Maryland Average 97%							
	94%	97%	96%	96%	95%	95%	97%	96%	98%	97%	96%	96%	97%	97%	96%

Data Source: CAHPS® Submission or Health Benefit Plan Records

continued

MHCC Supplemental Questions and Answers continued

Question	HMO							PPO							
	Aetna	CareFirst BlueChoice	Coventry	Kaiser Permanente	MD-IPA	Optimum Choice	United-Healthcare	Aetna	CareFirst GHMSI	CareFirst CFMI	Cigna	Coventry	KPIC	MAMSI	United-Healthcare
Doctors are Caring and Inspire Trust															
In the last 12 months, did you feel you could tell your personal doctor anything, even things that you might not tell anyone else? **RESPONSE USED: Yes, Definitely**	Maryland Average 58%							Maryland Average 59%							
	58%	58%	61%	58%	57%	55%	56%	59%	58%	58%	62%	61%	52%	60%	61%
In the last 12 months, did you feel you could trust your personal doctor with your medical care? **RESPONSE USED: Yes, Definitely**	Maryland Average 81%							Maryland Average 82%							
	81%	83%	81%	80%	81%	82%	78%	79%	80%	84%	83%	85%	77%	81%	84%
In the last 12 months, did you feel that your personal doctor always told you the truth about your health, even if there was bad news? **RESPONSE USED: Yes, Definitely**	Maryland Average 89%							Maryland Average 91%							
	89%	91%	92%	87%	87%	90%	88%	91%	93%	90%	92%	90%	92%	90%	92%
In the last 12 months, did you feel that your personal doctor cared as much as you do about your health? **RESPONSE USED: Yes, Definitely**	Maryland Average 74%							MarylandAverage 75%							
	76%	75%	77%	74%	74%	71%	69%	73%	75%	77%	76%	78%	68%	75%	80%
In the last 12 months, did you feel that your personal doctor really cared about you as a person? **RESPONSE USED: Yes, Definitely**	Maryland Average 73%							Maryland Average 74%							
	74%	74%	79%	74%	73%	70%	68%	72%	71%	74%	75%	76%	70%	77%	79%

Data Source: CAHPS® Submission or Health Benefit Plan Records

V. STATEWIDE HEALTH CARE INITIATIVES

Maryland Health Care Commission's Center for Quality Measurement and Reporting

The **Health Benefit Plan Quality and Performance** division is committed to promoting improvements in health care by fulfilling its legislative charge to establish and maintain a Quality and Performance Evaluation System of measurement and reporting for managed care plans operating in the State of Maryland. Health benefit plan disclosure of information using reliable, audited, standardized quality measures and indicators helps consumers and employers evaluate specific areas of interest and overall performance of health benefit plans. The Division is tasked with:

- Management of the Health Benefit Plan Quality and Performance Evaluation System, which uses a variety of quality tools to measure the performance of commercial health benefit plans in the State of Maryland.
- Leading the development and implementation of the Maryland Race/Ethnicity, Language, Interpreters, and Cultural Competency Assessment (RELICC™) tool that is being used by MHCC and the Maryland Health Benefit Exchange to evaluate and report on commercial health benefit plans' and qualified health plans' initiatives to address disparities.
- Production of comparative public reports, including the Consumer Edition of the Maryland Health Care Commission Quality Report 2014, the Maryland Health Care Commission Comprehensive Quality Report 2014, and the Maryland Health Connection Quality Report 2014, all of which are typically used by employers, individuals and the State Employee Benefits program to assist Marylanders in their choice of a health benefit plan while shopping for health insurance.

The division of **Long Term Care Quality and Performance** focuses on improving long-term and community-based care through collection and report of performance and quality measures for services. An interactive web-based consumer guide is the platform for presenting information about Maryland long term care (LTC) service providers. The *Maryland Guide to Long Term Care Services* provides users an easy way to locate and compare nursing homes, assisted living residences, home health agencies, adult day care, and hospice programs on services offered and quality and performance measures where available.

- LTC quality measures include: results of the Office of Health Care Quality (OHCQ) annual licensing and complaint surveys; staff influenza vaccination rates, results of Experience of Care surveys for nursing homes and home health agencies, and outcome and process measures on various aspects of care.
- Division staff works with federal agencies such as the Centers for Medicare and Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ) and other national organizations such as the National Quality Forum (NQF) to ensure that the quality measures reported within the *Maryland Guide to LTC Services* are reliable, validated, and suitable for public reporting. This work also follows national trends in LTC quality to keep quality and performance measures in Maryland on the "cutting edge."

The **Hospital Quality and Performance** division is responsible for providing meaningful information to consumers, practitioners, and policymakers about the quality and outcomes of care provided in all Maryland acute care hospitals. The division is responsible for producing the Hospital Performance Evaluation Guide (Hospital Guide), a web-based resource, which contains both general information and specific quality and performance measures. Key priorities of the division include:

- Reporting on the hospital adherence to evidence based standards of care
- Reporting on the patients' assessment of the care provided during their hospital stay
- Reporting on the most common conditions treated in Maryland hospitals, including maternity and newborn care
- Reporting the rates of key hospital acquired infections and related initiatives
- Auditing the data to ensure the accuracy and completeness of the information displayed on the Hospital Guide
- Reporting on hospital charges for common conditions identified using Diagnosis Related Groups
- Enhancements as part of the Commission's price transparency initiative are underway
- A system for reporting on hospital performance related to specialized cardiac services is under development

The division works closely with the Health Services Cost Review Commission (HSCRC), Maryland's hospital rate setting agency, to support the data requirements associated with the Quality-Based Reimbursement initiative and the Medicare Waiver Project.

V. STATEWIDE HEALTH CARE INITIATIVES

Maryland Health Benefit Exchange (MHBE)

On March 23, 2010, the Patient Protection and Affordable Care Act (ACA) was signed into law by President Barack Obama. A key provision of the law requires all states to participate in health insurance exchanges beginning January 1, 2014. A health insurance exchange is a marketplace to help individuals, families and small businesses shop for coverage through easy comparison of available plan options based on price, benefits and services, and quality.

Maryland's Health Benefit Exchange model is a state-based marketplace called Maryland Health Connection. As a state-based exchange, Maryland is responsible for the development and operation of the following core functions:

- Consumer support for coverage decisions
- Approval of participating carriers
- Certification of plans as Qualified Health Plans (QHPs)
- Eligibility determinations for individuals and calculations of cost sharing reductions and tax subsidies
- Enrollment in qualified health plans (QHPs) and qualified dental plans (QDPs)

The ACA requires that QHPs meet all applicable federal and state laws in order to be certified. Additionally, all QHPs operating via Maryland Health Connection and available to consumers must offer a core set of "essential health benefits" as defined by the U.S. Department of Health and Human Services. The State of Maryland performs a review to ensure compliance with all areas required in the ACA.

To assist consumers with plan selection when they shop for plans on Maryland Health Connection, MHCC and MHBE have an agreement that enables MHBE to utilize quality data from carriers in this report as a proxy for quality data by the same carrier with similar product offerings inside the exchange. Each carrier's aggregated results from this report form the basis of a 5-star rate for each QHP in the Maryland Health Connection Quality Report 2014, for consumer use during open enrollment beginning on November 15, 2014. Each QHP's 5-star rate will also be displayed on the Maryland Health Connection website. Carriers new to the individual market in Maryland will not be assigned a 5-star rate.

Quality is just one of the plan selection tools that consumers may utilize on Maryland Health Connection. Other plan selection tools include a provider search, a Summary of Benefits and Coverage (SBC) for each plan, side-by-side plan comparison, icons that indicate whether or not a plan includes dental benefits for children or adults, and the ability to sort on premium price, annual cost, and carrier.

Individual consumers may shop on Maryland Health Connection during an Open Enrollment period. The first open enrollment period was held from October 1, 2013 through March 31, 2014. For coverage beginning in 2015, the proposed open enrollment period is November 15, 2014 through January 15, 2015. Individuals may enroll outside of Open Enrollment if they experience a qualifying life event, such as a change in household composition or a change in income.

For more information about how to enroll, visit the Maryland Health Connection website at **http://www.marylandhealthconnection.gov**. Here you will find many enrollment resources as well as the eligibility and enrollment portal. In order to speak directly to a Customer Service Representative, please call the Consumer Support Center at 1-855-642-8572 or 1-855-642-8573 (TTY services for deaf and hard of hearing).

You may also visit any Connector Entity for in-person assistance: **http://marylandhealthconnection.gov/health-insurance-in-maryland/help-with-health-insurance/health-insurance-support/connector-organizations/**

For more information about the Maryland Health Benefit Exchange, such as policy documents and information on public meetings, visit the stakeholder website at **http://marylandhbe.com**.

V. STATEWIDE HEALTH CARE INITIATIVES

Maryland Multi-payor Patient Centered Medical Home Program (MMPP)

The Maryland PCMH Pilot Study

Maryland's Patient-Centered Medical Home (PCMH) program positions the State as a leader in innovative efforts for improving health and well-being. Maryland's PCMH pilot study is known as the Maryland Multi-payor Patient Centered Medical Home Program (MMPP). The pilot program was initiated following legislation in 2010 and will run through December 31, 2015. The MMPP currently includes roughly 52 physician practices and provides value to both patients and the health care community by offering a new care delivery model that has the potential to improve patient outcomes and reduce costs. In the future, the number of practices that participate in a PCMH model of care delivery is expected to increase statewide. There are other PCMH pilot studies in Maryland as well.

A uniqueness of the MMPP as compared to many other PCMH programs nationally is the diversity of participating health plan sponsors. The existing PCMH law requires the five largest State-regulated payors (Aetna, CareFirst BlueCross BlueShield, Cigna Health Care, Coventry Health Care, and UnitedHealthcare) to financially support the program by providing upfront and incentive payments to MMPP practices that qualify.[1] Other health plan sponsors have elected to participate in the MMPP, including many of the Maryland Medical Assistance managed care organizations, Federal Employees Health Benefits Program, Maryland State Employees Health Benefit Plan, TRICARE (the health care program serving Uniformed Service members), and private employer-sponsored health plans, such as the Anne Arundel Medical Center employee health benefit plan.

The PCMH is a new model of health care delivery where patients have a long-term, ongoing relationship with a provider. The provider coordinates a cooperative team of health care providers, which may include primary care or specialty physicians, community based providers, nurse practitioners, physician assistants, medical assistants, registered nurses, and care coordinators. A pharmacist may also be part of the team, since managing medications can be challenging.

MARYLAND PATIENT CENTERED MEDICAL HOME

There are many benefits of the PCMH model for the patient. In a PCMH, your health care team:

- Focuses on you, the patient
- Coordinates care among all of your providers within the team and other physicians, if necessary
- Takes overall responsibility for your care
- Follows up after you're hospitalized, to make sure your recovery is progressing as planned to keep you from going back in the hospital
- Identifies appropriate specialists you may need to see
- May arrange a pharmacy consult for you to ensure that you understand how to take all of your medications

Coordination of care is also enhanced when patients sign up for a secure, online health management tool that connects patients to portions of their personalized health information. With one of these accounts, you may be able to:

- Review past appointments, request and cancel appointments
- Request your prescription renewals
- Access your health summary, current list of medications and test results as released by your physician
- Get important health reminders

[1] MD. Code Ann., Health-Gen. § 19-1A-02., enacted as Senate Bill 855, House Bill 929 (2010). Carriers with over $90 million in written premiums for health benefit plans in the State in the most recent reporting year are classified as large carriers.

V. STATEWIDE HEALTH CARE INITIATIVES

Health Information Technology (health IT)

Technology is changing the way we manage our health. The term health information technology (health IT) encompasses an array of technologies to store, share, and analyze health information. Health care providers are increasingly using health IT to improve patient care. You can use health IT to better communicate with your physician, learn and share information about your health, and take actions that will improve your quality of life. Key components of health IT include: electronic health records (EHRs), personal health records (PHRs), health information exchange (HIE), and telemedicine.

Physicians have generally kept medical records in paper charts, which include your health history, allergies, test results, and medications. Increasingly, physicians are using EHRs to store patient health information in a digital format, which enables them to more efficiently keep track of your health information. For example, using an EHR allows your physician to be alerted if you are due for preventive screenings or checkups. EHRs also enable your physician to access your medical history when you have a health problem even if the physician is not at their office. Some EHRs also allow you to log in to a patient portal where you can view your own health record and communicate with your physician through a secure messaging system.

In addition to EHRs, there are systems that enable you to set up and maintain your own health information in a personal health record known as a PHR. You can set up a PHR using an online service or other software. In some cases, your physician or insurance company may offer a PHR for use by patients. You can use a PHR to store your health history, such as illnesses, allergies, medications, immunizations, and test results. PHRs can also be used to store other information, such as emergency contacts, and to keep of track of health-related activities, such as diet, exercise, and sleep.

Physicians can participate in HIEs, which are entities that store health information submitted by different health care providers. HIEs allow physicians to view available patient health information and gain access to the most up to date information about their patients, enabling physicians to better coordinate patient care, reconcile prescribed medications, and reduce duplicate medical tests.

Maryland has a statewide HIE: the Chesapeake Regional Information System for our Patients, also known as CRISP. CRISP includes patient health information from Maryland hospitals and other health facilities, such as laboratory and radiology centers. Health care providers can join the HIE to access available clinical information on their patients by searching for patient demographics, laboratory results, radiology reports, discharge summaries, operative notes, and medication history. Health care providers can also sign up to receive automatic alerts when one of their patients is admitted, discharged, or transferred at a Maryland hospital. By using these HIE services, health care providers have electronic access to information about their patients' hospital encounters, instead of waiting to receive paper or faxed medical records. This enables health care providers to ensure appropriate follow-up care when a patient is discharged from the hospital.

Balancing the need for information sharing with the need for strong privacy and security policies is a central focus of Maryland's HIE efforts. CRISP follows both State and Federal laws to protect patient health information. Additionally, patients can choose to opt out of being included in CRISP, which means your health information will not be accessible to health care providers participating with CRISP, except for certain limited instances (including public health reporting as required by law and for controlled dangerous substances as required under Maryland law). Although CRISP does not have a patient portal where patients can access their health information at this time, patients can request from CRISP a list of their health records that are available in the HIE, the health care providers who created the records and those who accessed them, as well as the providers who requested automated alerts about a patient's hospital encounters.

More health care providers are seeing their patients virtually through the Internet, which is known as telemedicine. Advancements in technology have made telemedicine even more widely available. For example, patients can video chat with their health care provider to avoid a trip to the office. Using a laptop, a video-chat account, and an Internet connection, you can consult a specialist, therapist, or a general practitioner from your living room. There are certain times when you will need a face to face visit with your physician. When you live far away from your physician, telemedicine can save time and make scheduling easier for everyone.

EHRs, PHRs, HIE, and telemedicine are tools to make your health care quality better, more efficient, and easier. The use of these tools can give your health care providers a more complete picture of your medical history and coordinate your care across different specialists. Ask your health care providers how you can participate and help to better manage your health information.

V. STATEWIDE HEALTH CARE INITIATIVES

Maryland Health Enterprise Zones (HEZ) Initiative

On April 10, 2012, with the support of the Maryland General Assembly, Governor Martin O'Malley signed the Maryland Health Improvement and Disparities Reduction Act into law. Implementation of this landmark legislation is under the leadership of Lt. Governor Anthony Brown. The Act seeks to address health disparities that impact the lives of many Marylanders. The law establishes a process through which the Secretary of the Department of Health and Mental Hygiene (DHMH), in collaboration with the Community Health Resources Commission (CHRC), designates Health Enterprise Zones (HEZs). The purpose of these zones is to reduce health disparities among racial and ethnic groups and geographic areas; improve health care access and health outcomes in underserved areas; and reduce health care costs and hospital admissions and readmissions.

The Act also requires Maryland Health Care Commission (MHCC) to establish and incorporate a standard set of measures regarding racial and ethnic variations in quality and outcomes and track health insurance carriers' and hospitals' efforts to combat disparities and to provide culturally appropriate educational materials. To this end, a chief priority for MHCC has been the recent development and implementation of the Maryland RELICC Assessment™, which is a health insurance carriers' quality and performance measurement tool that focuses on race/ethnicity, language, interpreter need, and cultural competency issues among Maryland's health insurance carriers. In addition, the Act requires state institutions of higher education that train health care professionals to report to the Governor and General Assembly on their actions aimed at reducing health disparities. Additional efforts by state institutions of higher education remain ongoing.

The HEZ Initiative is entering the second year of a four-year pilot program with a budget of $4 million per year. A steering committee led by Secretary of Health and Mental Hygiene, Dr. Joshua Sharfstein, continues to guide the implementation of the HEZ Initiative. To receive designation as a HEZ, community organizations and local health departments applied to DHMH and CHRC, identifying a comprehensive plan to address disparities in a contiguous geographic area, defined by zip code boundaries, with a documented population of at least 5,000, which is thought to be small enough to allow incentives to have a significant impact. Each applicant organization was also required to demonstrate economic disadvantage and poor health outcomes, with documented evidence of health disparities.

Maryland's first five HEZs are in the following locations:

- Capitol Heights in Prince George's County
- Greater Lexington Park in St. Mary's County
- Dorchester and Caroline Counties
- West Baltimore
- Morris Blum in Annapolis

Several possible incentives that can be utilized to address disparities within the HEZs include the following:

- Loan assistance repayment
- State income tax credits
- Hiring tax credits
- Priority to enter the Maryland Patient Centered Medical Home Program
- Grant funding for capital improvements and medical/dental equipment
- Priority for receiving funds for establishing electronic health records

For more information on HEZs, visit: **http://dhmh.maryland.gov/healthenterprisezones/SitePages/Home.aspx**

V. STATEWIDE HEALTH CARE INITIATIVES

Million Hearts® Initiative

The Maryland Department of Health and Mental Hygiene (DHMH) supports the Million Hearts® Initiative. Million Hearts® is a national initiative that was launched by the Department of Health and Human Services in September 2011 to prevent 1 million heart attacks and strokes in the United States by 2017.

Heart disease and stroke are among the top causes of death in Maryland, responsible for one out of three deaths. Heart disease accounted for 24.9 percent of deaths, and stroke accounted for 5.2 percent of total deaths in 2010. In Maryland, 37.4 percent of adults reported high cholesterol and 30.1 percent of adults reported high blood pressure in 2009, and 15.2 percent of adults were current smokers in 2010. We also know that members of minority communities in Maryland experience these risk factors at even higher rates. Most risk factors for heart disease and stroke – specifically high blood pressure, high cholesterol, diabetes, smoking, and obesity – are preventable and controllable. Controlling these risk factors can reduce the risk of heart attack or stroke by more than 80 percent.

Maryland's commitment to the Million Hearts® Initiative has five core components:

- Improving clinical care
- Strengthening tobacco control
- Promoting a healthy diet
- Encouraging workplace wellness
- Incentivizing local public health action

Maryland's Million Hearts® activities are a central component of an overall health reform strategy that aims to expand access to high quality health care for all Marylanders and maximize wellness and prevention to optimize the value of the state's investment in health. Progress will be tracked through StateStat, a performance measurement and management tool implemented by Governor Martin O'Malley, to improve state government efficiency and accountability. DHMH recently added to its StateStat reporting a template specific to the Million Hearts® Initiative that tracks data with the goal of controlling blood pressure, improving control of diabetes and reducing cardiovascular mortality. The template can be found at:
http://www.dhmh.maryland.gov/statestat/SitePages/Home.aspx

Maryland's Million Hearts® strategies align with Maryland's recent award of a $9.7 million Centers for Disease Control and Prevention Community Transformation Grant (CTG) to expand the Healthiest Maryland efforts in "making the healthiest choice the easiest choice" for all Marylanders, particularly for Marylanders with existing heart disease and stroke risk factors. From May 2012 to September 2013, the Preventive Health and Health Services (PHHS) Grant was used to expand Maryland's Million Hearts® activities to Baltimore City, and Baltimore, Montgomery, Prince George's, and Anne Arundel counties. The CTG and PHHS Grants together allow for a statewide reach and measurable impact by reducing tobacco use; increasing physical activity; enhancing the food environment (including reducing sodium and eliminating trans fat in the food supply); and providing community-clinical linkages to improve control of blood pressure and cholesterol levels.

To learn more about the Million Hearts® Initiative, visit:
http://millionhearts.hhs.gov/index.html

VI. FIVE CHRONIC DISEASES IMPACTING MARYLAND RESIDENTS

Chronic diseases or conditions are prolonged illnesses that usually last more than six months, are not able to be spread to others like an infection, require treatment because they do not resolve on their own, and are rarely cured completely. They affect people of all ages and ethnicities but are more common among older adults, especially those belonging to ethnic minority groups. Empowering patients to appropriately manage their chronic conditions is a leading health priority for the State of Maryland. There is mounting evidence that a comprehensive approach to care management can save tremendous costs and unnecessary suffering. Five chronic conditions impacting Maryland residents include Obesity, Cardiovascular Disease, Diabetes, Asthma, and Chronic Obstructive Pulmonary Disease (COPD).

VI. FIVE CHRONIC DISEASES IMPACTING MARYLAND RESIDENTS

"People with a body mass index (BMI) of 30 or higher are considered obese. The term "obesity" is used to describe the health condition of anyone significantly above his or her ideal healthy weight. Don't be discouraged by the term. It simply means you are 20% or more above your ideal weight, and you are not alone.

Nearly 70% of American adults are either overweight or obese. Being obese puts you at a higher risk for health problems such as heart disease, stroke, high blood pressure, diabetes and more."

(American Heart Association, 2014)

Obesity

Finding Your Healthiest Weight

Losing a few pounds can bring you cardiovascular benefits, so setting personal goals is a step toward healthier living. Consider these reasons to work toward maintaining a healthy weight.

A healthy weight promotes more efficient blood circulation, better fluid management, and decreases the chances of diabetes, heart disease, some cancers, and even sleep apnea.

Carrying too much weight as body fat can put you at greater health risk and promote a rise in your blood cholesterol and triglyceride levels, lower your "good" HDL cholesterol level, increase your blood pressure, and induce diabetes.

Working With Your Doctor

Calculating your BMI annually is an excellent way to start. If your BMI is over 30, you are considered obese and should consult with a physician to make a plan for treatment.

A weight loss treatment plan may include aerobic exercise for a minimum of 30 minutes a day, reducing your caloric intake to improve your ability to burn stored energy (fat) and learning the skills to develop healthy behaviors.

Surgery may be a consideration for those who suffer from severe obesity, or who have one or more obesity-related health problems.

American Heart Association Recommendations

The American Heart Association recommends obese patients participate in a medically supervised weight loss program two or three times a month for at least six months.

Talk with your doctor about obesity screening and your best treatment options for weight loss.

Source: American Heart Association

http://www.heart.org/HEARTORG/GettingHealthy/WeightManagement/Obesity/Obesity-Information_UCM_307908_Article.jsp

VI. FIVE CHRONIC DISEASES IMPACTING MARYLAND RESIDENTS

"Cardiovascular disease, also called heart and blood vessel disease, includes numerous problems, many of which are related to a process called atherosclerosis. Atherosclerosis is a condition that develops when a substance called plaque builds up in the walls of the arteries. This buildup narrows the arteries, making it harder for blood to flow through. If a blood clot forms, it can stop the blood flow. This can cause a heart attack or stroke."

(American Heart Association, 2014)

Cardiovascular Disease

Defining Cardiovascular Disease

Cardiovascular disease is a group of heart and blood vessel disorders that include:

- Coronary Heart Disease – disease of the blood vessels supplying the heart muscle
- Cerebrovascular Disease – disease of the blood vessels supplying the brain
- Peripheral Arterial Disease – disease of blood vessels supplying the arms and legs
- Pulmonary Embolism – blood clots can dislodge and move to the heart and lungs

Heart attacks and strokes are usually acute and mainly caused by a blockage that prevents blood from flowing to the heart or brain. The most common reason for this is a build-up of fatty deposits in blood vessels.

Risk Factors for Cardiovascular Disease

Behavioral risk factors account for about 80% of heart diseases. The most important behavioral risk factors of cardiovascular disease are unhealthy diet, physical inactivity, tobacco use and harmful use of alcohol.

The effects of unhealthy diet and physical inactivity may appear as raised blood pressure or blood glucose and obesity. These "intermediate risks factors" can be measured by a physician and indicate an increased risk of developing a heart attack, stroke, or other complications.

Cessation of tobacco use, reduction of salt in the diet, consuming fruits and vegetables, regular physical activity and avoiding harmful use of alcohol reduce the risk of cardiovascular disease. The risk can also be reduced by preventing or treating hypertension and diabetes.

Talk with your doctor about screening and your best treatment options.

Source: World Health Organization
http://www.who.int/mediacentre/factsheets/fs317/en/

VI. FIVE CHRONIC DISEASES IMPACTING MARYLAND RESIDENTS

"Diabetes mellitus refers to a group of diseases that affect how your body uses blood glucose, commonly called blood sugar. Glucose is vital to your health because it's an important source of energy for the cells that make up your muscles and tissues. It's also your brain's main source of fuel.

If you have diabetes, no matter what type, it means you have too much glucose in your blood, although the reasons may differ. Too much glucose can lead to serious health problems."

(Mayo Clinic, 2013)

Diabetes

Understanding the Disease

Diabetes is a group of diseases characterized by high blood glucose levels that result from defects in the body's ability to produce and/or use insulin.

There are three types of diabetes:

Type 1, previously known as juvenile diabetes, as it is usually diagnosed in childhood

Type 2, the increasingly common type in adults

Type 3, also known as gestational diabetes, in which a pregnant woman can develop diabetes for the duration of her pregnancy but will recover soon after delivery.

Diabetes is a serious but manageable disease; it causes more deaths per year than breast cancer and AIDS combined. Having gestational diabetes can increase a woman's risk of developing Type 2 diabetes later in life. In addition, having family members with diabetes, injury to or disease of the pancreas, hypertension, or obesity are also risk factors in the development of diabetes.

Sources: American Diabetes Association

http://www.diabetes.org/diabetes-basics/?loc=GlobalNavDB

National Library of Medicine

http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001898/

Resources/Helpful Hints

As with all chronic diseases, it's important to know your risk. Age, family history, weight, and nutrition can all contribute to your risk of developing Type 2 or gestational diabetes. Talk to your doctor about lessening your risk through improving your diet, i.e., reducing your sugar intake. The American Diabetes Association provides recipes, lifestyle tips and access to an online community that provides a support network for getting involved and knowing your rights within the community and at the work place.

Source: American Diabetes Association

http://www.diabetes.org/living-with-diabetes/

Things You Need to Know

Type 1 diabetes is caused by genetics and unknown factors that trigger the onset of the disease. Type 2 diabetes is caused by genetics, which you cannot change, and lifestyle factors, which you can. Research has shown that drinking sugary drinks is linked to Type 2 diabetes. The American Diabetes Association recommends that people should limit their intake of sugar-sweetened beverages to help prevent diabetes. Sugar-sweetened beverages include beverages like regular soda, fruit punch/drinks, sports/energy drinks, and sweet tea.

Source: American Diabetes Association

http://www.diabetes.org/diabetes-basics/diabetes-myths/

VI. FIVE CHRONIC DISEASES IMPACTING MARYLAND RESIDENTS

"Asthma is a chronic (long-term) lung disease that inflames and narrows the airways. Asthma causes recurring periods of wheezing (a whistling sound when you breathe), chest tightness, shortness of breath, and coughing. The coughing often occurs at night or early in the morning.

Asthma affects people of all ages, but it most often starts during childhood. In the United States, more than 25 million people are known to have asthma. About 7 million of these people are children.

Asthma has no cure. Even when you feel fine, you still have the disease and it can flare up at any time. However, with today's knowledge and treatments, most people who have asthma are able to manage the disease. They have few, if any, symptoms. They can live normal, active lives and sleep through the night without interruption from asthma."

(National Institutes of Health, 2012)

Asthma

Understanding the Disease

Asthma creates swollen and red (or inflamed) airways in the lungs. People with asthma become sensitive to environmental and/or everyday asthma "triggers." A trigger can be a cold or respiratory infection, the weather, or things in the environment, such as dust, chemicals, smoke, and pet dander. When a person with asthma breathes in a trigger, the insides of the airways make extra mucus and swell even more. This narrows the space for the air to move in and out of the lungs, making it difficult to breathe.

Source: American Lung Association
http://www.lung.org/lung-disease/asthma/learning-more-about-asthma/

Resources/Helpful Hints

Though some risk factors, like your genetics or family history, cannot be modified, many risk factors can be managed. Take care of your lungs, avoid secondhand smoke and limit your exposure to chemicals. Avoid outdoor activities on bad air quality days. It is important to treat colds and respiratory infections quickly and as directed by your doctor. Protect yourself against contagions during the cold and flu season, practice good oral hygiene (protecting your mouth from germs), get vaccinated against influenza, and protect others by staying home from work or school when you get sick with a contagious illness. Asthma is a treatable disease that with monitoring and proper medication can allow you to live a normal and productive life. Check your local air quality at **www.stateoftheair.org** before engaging in an outdoor activity. It's important for everyone, not just those who live with asthma.

Source: American Lung Association
http://www.lung.org/your-lungs/protecting-your-lungs/

Things You Need to Know

Although the exact cause of asthma is not known, the following factors play an important role in the development and worsening or exacerbation of asthma:

Genetics. Asthma tends to run in families.

Allergies. Some people are more likely to develop allergies than others, especially if your parents had allergies. Certain allergies are linked to people who get asthma.

Respiratory Infections. As the lungs develop in infancy and early childhood, certain respiratory infections have been shown to cause inflammation and damage the lung tissue.

Environment. Contact with allergens, certain irritants, or exposure to viral infections as an infant or in early childhood when the immune system is developing have been linked to developing asthma. Irritants and air pollution may also play a significant role in adult-onset asthma.

Source: American Lung Association
http://www.lung.org/lung-disease/asthma/

VI. FIVE CHRONIC DISEASES IMPACTING MARYLAND RESIDENTS

"COPD, or chronic obstructive pulmonary disease, is a progressive disease that makes it hard to breathe. COPD can cause coughing that produces large amounts of mucus, wheezing, shortness of breath, chest tightness, and other symptoms.

COPD develops slowly. Symptoms often worsen over time and can limit your ability to do routine activities. Severe COPD may prevent you from doing even basic activities like walking, cooking, or taking care of yourself.

COPD has no cure yet, and doctors don't know how to reverse the damage to the airways and lungs. However, treatments and lifestyle changes can help you feel better, stay more active, and slow the progress of the disease."

(National Institutes of Health, 2013)

Chronic Obstructive Pulmonary Disease (COPD)

Understanding the Disease

Chronic obstructive pulmonary disease (COPD) refers to a group of lung diseases that blocks airflow as you exhale; if left untreated COPD can cause serious, long term disability. Often, symptoms are mistaken by patients as normal results of aging or simply being out of shape. COPD is the third leading cause of death in the United States; however, it is treatable and preventable. Damage to the airways is most often caused by long-term tobacco smoke use or exposure to secondhand smoke, but can also be caused by exposure to harmful chemicals and/or air pollution.

Source: American Lung Association

http://www.lung.org/lung-disease/copd/living-with-copd/life-change.html

Resources/Helpful Hints

COPD is highly preventable and very easy to diagnose with a simple breathing test. The National Heart, Lung, and Blood Institute's campaign *COPD: Learn More Breathe Better*, is meant to educate those at risk of developing COPD and raise awareness about the ease of diagnosis and the testing for COPD. More than 12 million people are diagnosed with COPD nationally and another estimated 12 million may have it and not know it. Your doctor can provide you with the best tools for coping with your condition.

Source: National Heart, Lung, and Blood Institute

http://www.nhlbi.nih.gov/health/public/lung/copd/

Prevention and Assistance

Unlike some diseases, COPD typically has a clear path to the cause and as a result to the prevention of developing COPD. Most cases are directly related to cigarette smoking, so the best way to prevent it is to never smoke or quit smoking as soon as possible. It's critical for smokers to find a tobacco-cessation program that will help you quit for good and give you the best chance for preventing damage to your lungs.

Source: National Heart, Lung, and Blood Institute

http://www.nhlbi.nih.gov/health/public/lung/copd/am-i-at-risk/index.htm

Things You Need to Know

Occupational exposure to chemical fumes and dust are other risk factors for COPD. Educate yourself on the best ways to stay protected (wearing a mask when necessary) to prevent lung damage.

Source: Mayo Clinic

http://www.mayoclinic.com/health/copd/DS00916

VII. CONSUMER RESOURCES

Links to MHCC Resources

Publications on the performance of health care facilities are available on the MHCC website, including the following web-based, interactive guides:

A Consumer's Guide to Getting and Keeping Health Insurance in Maryland is a 45-page guide that explains rights and protections that apply to health insurance coverage in Maryland. Information is provided for individuals who buy their own health insurance or who get coverage through an employer, or for small business owners who offer health insurance to their employees.
http://mhcc.maryland.gov/mhcc/pages/plr/plr_Insurance/documents/CQM_SGM_2010_ConsumerGuide_Getting_Keeping_Health_Insurance_GUID_20100701.pdf

Maryland Guide to Long Term Care Services helps consumers locate and compare Maryland long-term care services: nursing homes, assisted-living residences, home health agencies, adult day care facilities, and hospice programs. Users can sort by services offered and by county or zip code; view recent results from Maryland Office of Health Care Quality's health and safety inspections; annual family satisfaction surveys; and find Internet links to many resources of interest to seniors, such as preparing for long term care needs.
http://mhcc.maryland.gov/consumerinfo/longtermcare/Default.aspx

Maryland Hospital Performance Evaluation Guide compares information on hospital characteristics, patient satisfaction ratings, quality scores, and selected health care associated infections (HAI) information. The site also features a pricing guide and other information about hospital services in Maryland.
http://mhcc.maryland.gov/consumerinfo/hospitalguide/index.htm

Maryland Ambulatory Surgery Facility Consumer Guide provides useful information for selecting an ambulatory surgery center. Users can find a surgical center by name, zip code, or medical specialty; download a checklist of questions to consider when having surgery in an outpatient center; and find information on what to do if they have a complaint.
http://mhcc.maryland.gov/consumerinfo/amsurg/

VII. CONSUMER RESOURCES

Links to Additional Information and Assistance

Inquiries and Complaints About Health Care Facilities and Practitioners

Assisted Living, Hospice, Hospitals, Labs, Nursing Homes –
Contact the Office of Health Care Quality
410-402-8000
http://dhmh.maryland.gov/ohcq/SitePages/Home.aspx

Physicians – *Contact the Board of Physicians*
410-764-4777
http://www.mbp.state.md.us/

Vaccinations

Local Health Department
http://msa.maryland.gov/msa/mdmanual/01glance/html/healloc.html

Vaccines for Children Program
http://phpa.dhmh.maryland.gov/OIDEOR/IMMUN/SitePages/vaccines-for-children-program.aspx

Inquiries and Complaints About Health Insurance for Consumers

Maryland Health Connection
http://marylandhealthconnection.gov/health-insurance-in-maryland/help-with-health-insurance/health-insurance-support/

Maryland Health Insurance Plan *(for residents without health insurance)*
http://www.marylandhealthinsuranceplan.state.md.us/

Maryland Insurance Administration
1-800-492-6116 or 410-468-2000
http://www.mdinsurance.state.md.us

Children's Health Insurance Program (CHIP)
1-800-456-8900
http://mmcp.dhmh.maryland.gov/chp/SitePages/Home.aspx

Has your health benefit plan refused to cover a medical procedure or pay for a medical service that has already been provided?
Contact the Maryland Attorney General's Health Education and Advocacy Unit
1-410-528-1840
http://www.oag.state.md.us/consumer/heau.htm

Bill Information/legislative/budget/statute questions?
Contact the Maryland General Assembly
http://mgaleg.maryland.gov/webmga/frm1st.aspx?tab=home

Maryland Links

Maryland Department of Health and Mental Hygiene
http://dhmh.maryland.gov

Maryland Health Benefit Exchange
http://marylandhbe.com

Medicaid Waivers
http://mmcp.dhmh.maryland.gov/waiverprograms/SitePages/Home.aspx

Maryland Office of Health Care Quality
http://dhmh.maryland.gov/ohcq/SitePages/Home.aspx

Maryland Licensed Health Care Facilities
http://dhmh.maryland.gov/ohcq/SitePages/Licensee%20Directory.aspx

Maryland Children's Health Programs
http://mmcp.dhmh.maryland.gov/chp/SitePages/Home.aspx

Maryland Local Health Departments
http://msa.maryland.gov/msa/mdmanual/01glance/html/healloc.html

Maryland Health Insurance Plan *(for residents without health insurance)*
http://www.marylandhealthinsuranceplan.state.md.us/

Maryland Insurance Administration
http://www.mdinsurance.state.md.us/sa/jsp/Mia.jsp

Maryland Board of Physicians
http://www.mbp.state.md.us/

Maryland Links continued

Maryland Board of Nursing
http://www.mbon.org/main.php

Maryland Pharmacy Board
410-764-4755
http://dhmh.maryland.gov/pharmacy/SitePages/Home.aspx

Maryland State Board of Dental Examiners
http://dhmh.maryland.gov/dental/SitePages/Home.aspx

Maryland Department of Aging
http://www.aging.maryland.gov/

Senior Health Insurance Assistance Program (SHIP)
http://www.aging.maryland.gov/StateHealthInsuranceProgram.html

Maryland Health Services Cost Review Commission
http://www.hscrc.state.md.us/

Maryland Vital Records *(birth, death, marriage, divorce certificates)*
http://dhmh.maryland.gov/vsa/SitePages/Home.aspx

Long Term Care Provider Contacts

Health Facilities Association of Maryland
http://www.hfam.org

LifeSpan Network
http://www.lifespan-network.org

Maryland Association for Adult Day Services
http://www.maads.org

Maryland National Capital Homecare Association
http://www.mncha.org

The Hospice & Palliative Care Network of Maryland
http://www.hnmd.org

COMAR Online

Title 10 – Department of Health and Mental Hygiene
http://www.dsd.state.md.us/comar/searchtitle.aspx?scope=10

Patient Safety

Maryland Patient Safety Center
http://www.marylandpatientsafety.org

Hospital Information

Maryland Hospital Association
http://www.mhaonline.org

CMS Hospital Compare
http://www.hospitalcompare.hhs.gov/

Joint Commission on Accreditation of Health Care Organizations
http://www.jointcommission.org

Hospital Quality Alliance
http://www.fah.org/fahcms/OnTheRecord/HospitalQualityAlliance.aspx

Assisted Living Information

Assisted Living Federation of America
http://www.alfa.org/alfa/Consumer_Corner.asp

National Center for Assisted Living
http://www.ahcancal.org/ncal/Pages/index.aspx

Assisted Living Facilities Organization
http://www.assistedlivingfacilities.org/

VII. CONSUMER RESOURCES | LINKS TO ADDITIONAL INFORMATION AND ASSISTANCE

Federal Links

CMS Nursing Home Compare
http://www.medicare.gov/nursinghomecompare/search.html

Department of Health and Human Services Administration on Aging
http://www.aoa.gov/

Medicaid
http://www.cms.hhs.gov/home/medicaid.asp

Medicare
http://www.medicare.gov

U.S. Department of Health and Human Services
http://www.hhs.gov/

U.S. Census Bureau
http://www.census.gov

National Links

American Association of Homes and Services for the Aging
http://www.leadingage.org/

Health Savings Accounts
http://www.nahu.org/consumer/HSAGuide.cfm

http://www.treasury.gov/resource-center/faqs/Taxes/Pages/Health-Savings-Accounts.aspx

Data Sources

The Commonwealth Fund
Maps with county-level and hospital referral region statistics, quality measures, health information technology adoption, population health, utilization & costs, readmission rates, mortality rates, as well as prevention and inpatient quality indicators **http://whynotthebest.org/maps**

VIII. INFORMATION ON METHODOLOGIES

Star Rating Methodology

Calculation of Relative Rates Using a 3-Star Rating System

Each performance measure and indicator included in this report contains health benefit plan performance rates for Maryland's individual and authorized combinations of HMO and PPO health benefit plans. Benchmark performance rates are also calculated in order to compare health benefit plan performance to overall State and national performance on each measure and indicator. The Maryland Average Benchmark (MAB) rate calculates a State average for each measure and indicator being reported. The National Average Benchmark (NAB) rate calculates a national average for each measure and indicator being reported.

The MAB rate forms the basis for the 3-Star rating system depicting relative performance of each health benefit plan on each measure and indicator being reported. All individual and authorized combinations of HMO and PPO health benefit plans contribute equally to the MAB for the HMO and PPO health benefit plan categories respectively. For the HMO category, the MAB is determined by adding the performance rate for each HMO and authorized HMO combination, and dividing by 7, because there are 7 health benefit plans being reported upon in the HMO category. For the PPO category, the MAB is determined by adding the performance rate for each PPO and authorized PPO combination, and dividing by 8, because there are 8 health benefit plans being reported upon in the PPO category. Health benefit plans in the HMO or PPO category for any performance measure or indicator with an NA or NR result instead of a performance rate, are excluded from the calculation of the MAB for the appropriate HMO or PPO category. Then, if the difference between a health benefit plan's actual performance rate (percent score) and the MAB is statistically significant, the health benefit plan is assigned one of three possible relative rates. Following are the symbols and a brief explanation of the three possible relative rates:

★★★ **The health benefit plan's performance is significantly better than the Maryland average**

When the difference between a health benefit plan's rate and the MAB for the appropriate HMO or PPO category is statistically significant **and** the health benefit plan's rate is "above" the Maryland average, the health benefit plan is assigned to the significantly "better than" the Maryland average category and receives 3 stars.

★★ **The health benefit plan's performance is equivalent to the Maryland average**

When the difference between a health benefit plan's rate and the MAB for the appropriate HMO or PPO category is statistically equivalent to the Maryland average, the health benefit plan is assigned to the "equivalent to" the Maryland average category and receives 2 stars.

★ **The health benefit plan's performance is significantly worse than the Maryland average**

When the difference between a health benefit plan's rate and the MAB for the appropriate HMO or PPO category is statistically significant **and** the health benefit plan's rate is "below" the Maryland average, the health benefit plan is assigned to the significantly "worse than" the Maryland average category and receives 1 star.

VIII. INFORMATION ON METHODOLOGIES

RELICC™ Methodology

In support of the Maryland Health Improvement and Disparities Reduction Act of 2012, Maryland Health Care Commission (MHCC) expanded the standardized collection and reporting of health benefit plan quality data related to disparities issues by developing and implementing the Maryland Race/Ethnicity, Language, Interpreters, and Cultural Competency Assessment (RELICC)™, a quality measurement instrument for use by health insurance carriers to assist in identifying, and ultimately eliminating health disparities. A major objective of RELICC™ is to determine if carriers gather appropriate information on their membership and their provider network in order to ensure that members are engaged and that culturally sensitive and appropriate care is delivered. The new tool was developed in collaboration with Maryland Health Benefit Exchange (MHBE), and with the participation and feedback of representatives from many of Maryland's health insurance carriers. The Mid-Atlantic Business Group on Health (MABGH) through the National Business Coalition on Health (NBCH), created the customized, quality measurement tool, based largely on the "Addressing Language and Health Literacy Needs" section of the proprietary eValue8™ Request For Information (RFI) tool. RELICC™ is an internet-based application securely administered by the application vendor, ProposalTech.

Credit is assigned to plan *responses* based on:

- Methods used to capture information on race/ethnicity, languages spoken and interpreter need of membership
- Knowledge of network and staff demographics and capabilities to support membership
- Whether information is captured proactively and directly rather than reactively (when member calls) or indirectly (imputed using zip code analysis, etc.)
- Breadth and depth in using data collected to meet member's needs (from language and culture perspective)
- Measurement of impact of language assistance activities
- Whether tools are provided that consider language and cultural needs (such as physician photo, if health assessment offered in different languages and via multiple ways including phone)

Upon completion by the health plan, the reviewer summarizes responses, marks certain questions for follow-up and assesses the attachments provided. If the follow-up responses and documents do not validate the plan's response(s), the response is changed in ProposalTech. Trained scorers conduct each review to ensure the following criteria are met:

1. Plan responses, including responses from nationally based health plans with multiple market locations, must only reflect services provided in Maryland.
2. Responses should be provided for a plan's commercial member population only. Medicaid or Medicare member data, initiatives or programs shall not be included in responses, except where explicitly requested.
3. Plans may delegate certain functions to an external vendor (disease management, pharmacy benefit management, behavioral health, or administrative services). If a plan fully delegates or collaborates with a vendor for any services, the plan should coordinate their Maryland RELICC Assessment™ responses with the vendor where appropriate.
4. In some health plans, varying degrees of delegation to provider groups or Independent Practice Associations (IPAs) exist. In recognition of plan models where providers accept a significant amount of delegation such as in generating performance reports, plans are asked to report approximate percentages of membership where provider groups generate patient-specific or performance reports and where the plan or a vendor may generate such reports.
5. All attachments to the Maryland RELICC Assessment™ must be labeled and submitted electronically. Requested attachments will be used to verify Maryland RELICC Assessment™ responses. Attachment examples include web screen shots and relevant newsletter articles.
6. All responses must be for 2013 data.

VIII. INFORMATION ON METHODOLOGIES

Maryland BHA and QP Methodologies

Maryland Plan Behavioral Health Assessment

The Maryland Plan Behavioral Health Assessment (BHA) is another Maryland-specific quality measurement instrument that details the health benefit plan's behavioral health care provider network. Information provided by the tool includes the following:

- Total counts of members with behavioral health benefits
- Maryland counties and jurisdictions where the health benefit plan operates and services are offered
- Total counts of practicing primary care and behavioral health care providers
- Accreditation status for the behavioral health care services program
- Percentage of psychiatrists that are board certified

Maryland Health Plan Quality Profile

The Maryland Health Plan Quality Profile (QP) is a Maryland-specific quality measurement instrument from which each health insurance carrier offers a summary of current Maryland initiatives implemented by the health benefit plans. The Maryland initiatives described by carriers focus on a core theme of "understanding and addressing health care disparities." Many of the initiatives include a focus on actions taken by each organization's leaders toward developing and implementing progressive programs that respond to changes in demographics, required services, and patient and provider expectations. All initiatives promote programs that respond to improving methods for collecting and reporting RELICC™-related information, ultimately promoting continuous quality improvement within each health benefit plan.

VIII. INFORMATION ON METHODOLOGIES

HEDIS® Methodology

The NCQA's Healthcare Effectiveness Data and Information Set (HEDIS®) is a proprietary health benefit plan performance evaluation tool that uses a standardized set of key performance measures and indicators to gather information from health benefit plans. This information, once audited and validated, is then able to be publicly reported so that consumers, employers and others can make direct comparisons of health benefit plan performance rates for each measure and indicator being reported.

Maryland Health Care Commission contracted with HealthcareData Company, LLC (HDC), a licensed HEDIS® firm, to conduct a full audit of the Maryland commercial health benefit plans as prescribed by *HEDIS 2014, Volume 5: HEDIS Compliance Audit®: Standards, Policies and Procedures*, published by NCQA.

A major objective of the audit is to determine the reasonableness and accuracy of how each health benefit plan collects data for performance reporting in Maryland.

The compliance audit focuses on two areas when evaluating each organization: an assessment of the organization's overall information system capabilities and an evaluation of its ability to comply with HEDIS® specifications for individual performance measures.

The HEDIS®-reporting organization follows guidelines for data collection and specifications for measure calculation described in *HEDIS® 2014, Volume 2: Technical Specifications*. For data collection, the health benefit plan pulls together all data sources, typically into a data warehouse, against which HEDIS® software programs are applied to calculate measures. Three approaches may be taken for data collection:

1. **Administrative data:** Data from transaction systems (claims, encounters, enrollment, practitioner) provide the majority of administrative data. Organizations may receive encounter files from pharmacy, laboratory, vision, and behavioral health vendors.
2. **Supplemental data:** NCQA defines supplemental data as atypical administrative data, i.e., not claims or encounters. Sources include immunization registry files, laboratory results files, case management databases, and medical record-derived databases.
3. **Medical record data:** Data abstracted from paper or electronic medical records may be applied to certain measures, using the NCQA-defined hybrid method. HEDIS® specifications describe statistically sound methods of sampling, so that only a subset of the eligible population's medical records needs to be chased. Use of the hybrid method is optional.

The percentages of data obtained from one data source versus another vary widely between health benefit plans, making it inappropriate to make across-the-board statements about the need for, or positive impact of, one method versus another. In fact, an organization's yield from the hybrid method may impact the final rate by only a few percentage points, an impact that is also achievable through improvement of administrative data collection systems.

Upon completion, the auditor approves the rate/result of each measure included in the HEDIS® report. If the auditor determines that a measure is biased, the organization cannot report a rate for that measure and the auditor assigns the designation of NR or "Not Reportable." Bias is based on the degree of error or data completeness for the data collection method used. NCQA defines four bias determination rules, applied to specific measures. The performance scores presented in this report reflect only measures deemed "Reportable" by the HEDIS® auditor.

VIII. INFORMATION ON METHODOLOGIES

CAHPS® Methodology

CAHPS® 5.0H Survey: Background

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey program is overseen by the United States Department of Health and Human Services – Agency for Healthcare Research and Quality (AHRQ) and includes a myriad of survey products designed to capture consumer, patient and health benefit plan member perspectives on health care quality. Maryland Health Care Commission (MHCC) has implemented use of the *CAHPS® Health Plan Survey 5.0H, Adult Version* as part of the Health Benefit Plan Quality and Performance Evaluation System.

The core of the CAHPS® survey is a set of questions used to measure satisfaction with the experience of care and includes four questions that reflect overall satisfaction and seven multi-question composites that summarize responses in key areas. Survey respondents are asked to use a scale of 0 to 10 to rate their doctor, their specialist, their experience with all health care, and their health benefit plan.

MHCC contracted with WBA Research, a survey vendor specializing in health care and other consumer satisfaction surveys, to administer the survey to members of the various health benefit plans included in this report.

In addition, MHCC contracted with a licensed HEDIS® audit firm, HealthcareData Company, LLC, to review programming codes used to create the list of eligible members to take part in the survey and to validate the integrity of the sample frame of those members before WBA Research randomly drew from the sample and administered the survey. Survey data collection began in mid-February 2014 and lasted into May 2014.

Summary-level data files generated by NCQA were distributed in June 2014 to each health benefit plan for a review of data before the authorized health benefit plan representative signed off attesting to the accuracy of the data pertaining to their health benefit plan that are now included in this public report.

Survey Methods and Procedures

Sampling: Eligibility and Selection Procedures

Health benefit plan members who are eligible to participate in the *CAHPS® Health Plan Survey 5.0H, Adult Version* had to be Maryland residents 18 years of age or older as of December 31 of the 2013 measurement year. They also had to be continuously enrolled in the commercial health benefit plan for at least 11 of the 12 months of 2013, and remain enrolled in the health benefit plan in 2014. Enrollment data sets submitted to the CAHPS® vendor are sets of all eligible members – the relevant population. All health benefit plans are required to have their CAHPS® data set (sample frame) audited by the licensed HEDIS® auditor before the data is sent to the survey vendor.

Survey Protocol

The CAHPS® survey employs a rigorous, multistage contact protocol that features a mixed-mode methodology consisting of a mail process and telephone follow-up attempts. This protocol is designed to maximize response rates and give different types of responders a chance to reply to the survey in a way that they find comfortable. For example, telephone responders are more likely to be younger, healthier, and male.

APPENDIX A. CHILDHOOD IMMUNIZATION INFORMATION FOR CONSUMERS

According to the Centers for Disease Control and Prevention (CDC), vaccine-preventable disease levels in the United States are at or near record lows. Vaccination against preventable disease protects children from unnecessary illness, disability and death. Supporting information is provided below for two quality measures on childhood immunization found earlier in this report.

Childhood Immunization Status (see page 64)

COMBINATION 10 IMMUNIZATION SERIES:

Combo 10	Diphtheria, Tetanus and acellular Pertussis	Inactivated Polio Virus	Measles, Mumps and Rubella	Haemophilus Influenza type B	Hepatitis B	Varicella (Chicken Pox) Zoster Virus	Pneumococcal Conjugate Virus	Hepatitis A	Rotavirus	Influenza
Abbreviation	DTaP	IPV	MMR	HiB	HepB	VZV	PCV	HepA	RV	Influenza
Inoculations ("Doses")	4	3	1	3	3	1	4	1	2 or 3	2

DTaP – At least four DTaP vaccinations, on different dates

IPV – At least three IPV vaccinations, on different dates

MMR – Any of the following:

- At least one MMR vaccination
- At least one measles and rubella vaccination and at least one mumps vaccination
- At least one measles vaccination and at least one mumps vaccination and at least one rubella vaccination

HiB – At least three HiB vaccinations, on different dates

HepB – Either of the following:

- At least three hepatitis B vaccinations, on different dates
- History of hepatitis

VZV – At least one VZV vaccination

PCV – At least four pneumococcal conjugate vaccinations, on different dates

HepA – At least one hepatitis A vaccination

RV – Any of the following:

- At least two doses of the two-dose rotavirus vaccine, on different dates
- At least three doses of the three-dose rotavirus vaccine, on different dates
- At least one dose of the two-dose rotavirus vaccine and at least two doses of the three-dose rotavirus vaccine, on different dates

Influenza – At least two influenza vaccinations, on different dates

Immunizations for Adolescents (see page 66)

COMBINATION 1 IMMUNIZATION SERIES:

Combo 1	Meningococcal Conjugate Vaccine	Tetanus, Diphtheria toxoids, and acellular Pertussis OR Tetanus diphtheria toxoids
Abbreviation	MCV	Tdap or Td
Inoculations ("Doses")	1	1

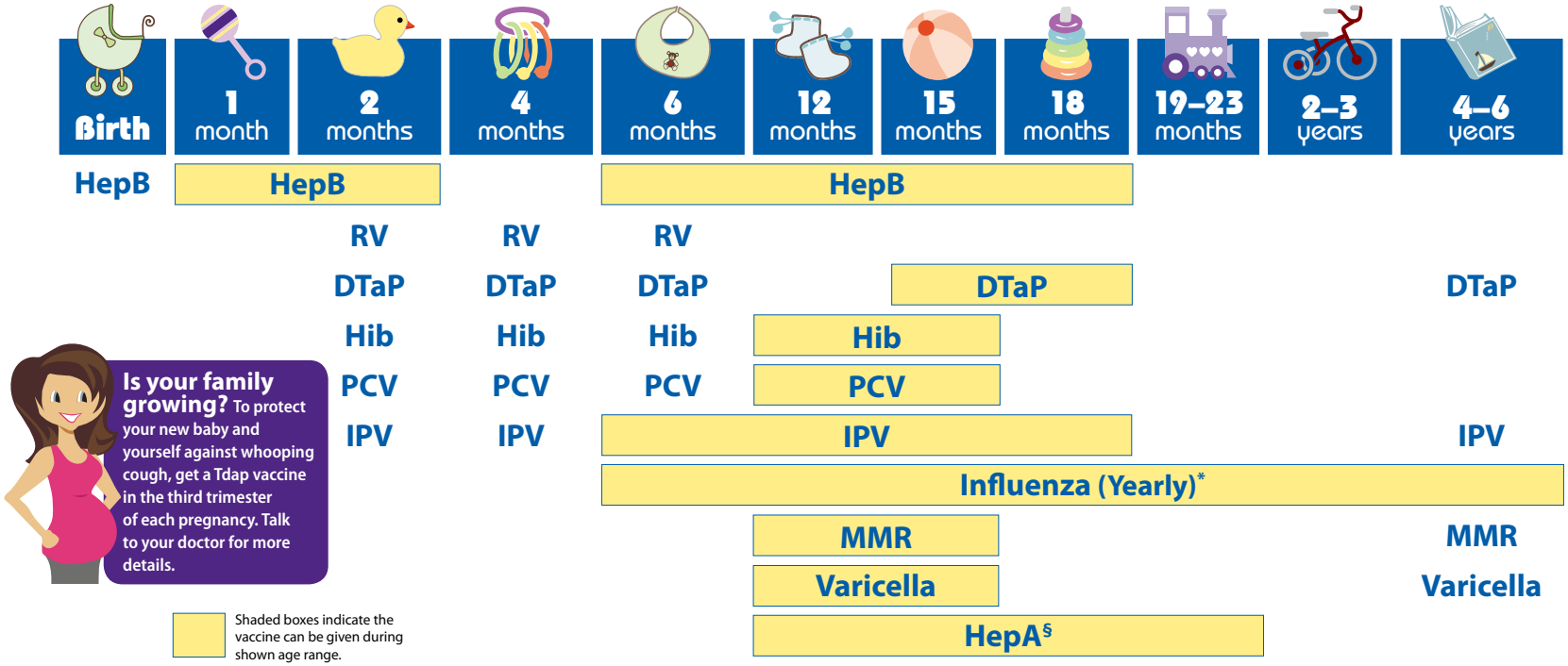
MCV – At least one meningococcal conjugate or meningococcal polysaccharide vaccine, on a date on or between the member's 11th and 13th birthdays

Tdap/Td – Any of the following on a date on or between the member's 10th and 13th birthdays:

- At least one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine
- At least one tetanus, diphtheria toxoids (Td) vaccine
- At least one tetanus vaccine and at least one diphtheria vaccine, on the same or different dates

APPENDIX A. CHILDHOOD IMMUNIZATION INFORMATION FOR CONSUMERS

2014 Recommended Immunizations for Children from Birth Through 6 Years Old



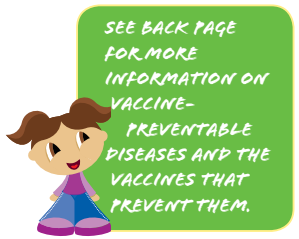
NOTE: If your child misses a shot, you don't need to start over, just go back to your child's doctor for the next shot. Talk with your child's doctor if you have questions about vaccines.

FOOTNOTES:

* Two doses given at least four weeks apart are recommended for children aged 6 months through 8 years of age who are getting a flu vaccine for the first time and for some other children in this age group.

§ Two doses of HepA vaccine are needed for lasting protection. The first dose of HepA vaccine should be given between 12 months and 23 months of age. The second dose should be given 6 to 18 months later. HepA vaccination may be given to any child 12 months and older to protect against HepA. Children and adolescents who did not receive the HepA vaccine and are at high-risk, should be vaccinated against HepA.

If your child has any medical conditions that put him at risk for infection or is traveling outside the United States, talk to your child's doctor about additional vaccines that he may need.



For more information, call toll free
1-800-CDC-INFO (1-800-232-4636)
or visit
http://www.cdc.gov/vaccines

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

APPENDIX A. CHILDHOOD IMMUNIZATION INFORMATION FOR CONSUMERS

Vaccine-Preventable Diseases and the Vaccines that Prevent Them

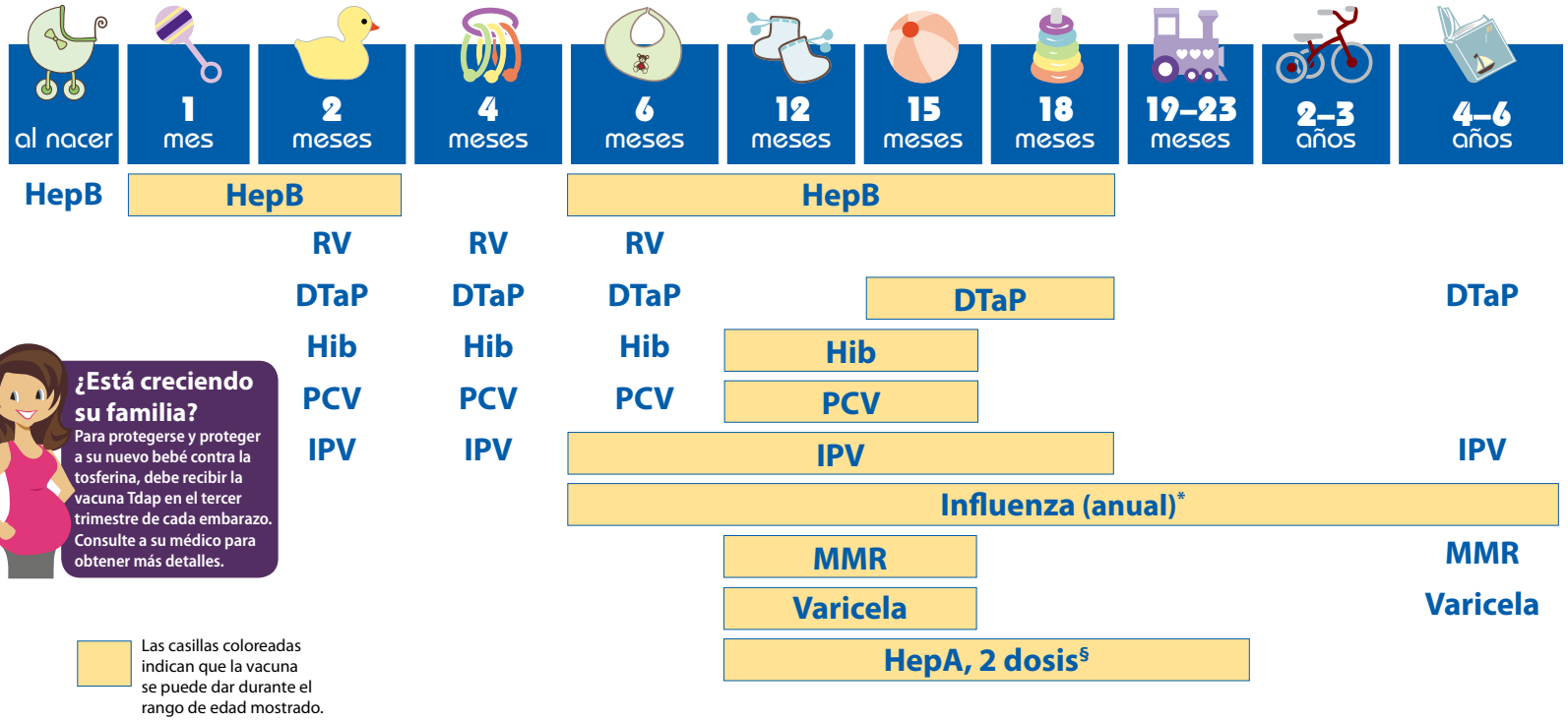
Disease	Vaccine	Disease spread by	Disease symptoms	Disease complications
Chickenpox	Varicella vaccine protects against chickenpox.	Air, direct contact	Rash, tiredness, headache, fever	Infected blisters, bleeding disorders, encephalitis (brain swelling), pneumonia (infection in the lungs)
Diphtheria	DTaP* vaccine protects against diphtheria.	Air, direct contact	Sore throat, mild fever, weakness, swollen glands in neck	Swelling of the heart muscle, heart failure, coma, paralysis, death
Hib	Hib vaccine protects against *Haemophilus influenzae* type b.	Air, direct contact	May be no symptoms unless bacteria enter the blood	Meningitis (infection of the covering around the brain and spinal cord), intellectual disability, epiglottitis (life-threatening infection that can block the windpipe and lead to serious breathing problems), pneumonia (infection in the lungs), death
Hepatitis A	HepA vaccine protects against hepatitis A.	Direct contact, contaminated food or water	May be no symptoms, fever, stomach pain, loss of appetite, fatigue, vomiting, jaundice (yellowing of skin and eyes), dark urine	Liver failure, arthralgia (joint pain), kidney, pancreatic, and blood disorders
Hepatitis B	HepB vaccine protects against hepatitis B.	Contact with blood or body fluids	May be no symptoms, fever, headache, weakness, vomiting, jaundice (yellowing of skin and eyes), joint pain	Chronic liver infection, liver failure, liver cancer
Flu	Flu vaccine protects against influenza.	Air, direct contact	Fever, muscle pain, sore throat, cough, extreme fatigue	Pneumonia (infection in the lungs)
Measles	MMR** vaccine protects against measles.	Air, direct contact	Rash, fever, cough, runny nose, pinkeye	Encephalitis (brain swelling), pneumonia (infection in the lungs), death
Mumps	MMR**vaccine protects against mumps.	Air, direct contact	Swollen salivary glands (under the jaw), fever, headache, tiredness, muscle pain	Meningitis (infection of the covering around the brain and spinal cord) , encephalitis (brain swelling), inflammation of testicles or ovaries, deafness
Pertussis	DTaP* vaccine protects against pertussis (whooping cough).	Air, direct contact	Severe cough, runny nose, apnea (a pause in breathing in infants)	Pneumonia (infection in the lungs), death
Polio	IPV vaccine protects against polio.	Air, direct contact, through the mouth	May be no symptoms, sore throat, fever, nausea, headache	Paralysis, death
Pneumococcal	PCV vaccine protects against pneumococcus.	Air, direct contact	May be no symptoms, pneumonia (infection in the lungs)	Bacteremia (blood infection), meningitis (infection of the covering around the brain and spinal cord), death
Rotavirus	RV vaccine protects against rotavirus.	Through the mouth	Diarrhea, fever, vomiting	Severe diarrhea, dehydration
Rubella	MMR** vaccine protects against rubella.	Air, direct contact	Children infected with rubella virus sometimes have a rash, fever, swollen lymph nodes	Very serious in pregnant women—can lead to miscarriage, stillbirth, premature delivery, birth defects
Tetanus	DTaP* vaccine protects against tetanus.	Exposure through cuts in skin	Stiffness in neck and abdominal muscles, difficulty swallowing, muscle spasms, fever	Broken bones, breathing difficulty, death

* DTaP combines protection against diphtheria, tetanus, and pertussis.
** MMR combines protection against measles, mumps, and rubella.

Last updated January 2014 • CS245366-A -

APPENDIX A. CHILDHOOD IMMUNIZATION INFORMATION FOR CONSUMERS

2014 Vacunas recomendadas para niños, desde el nacimiento hasta los 6 años de edad



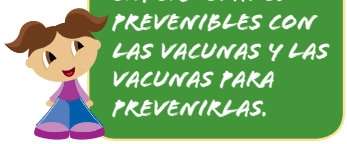
NOTA:
Si su hijo no recibió una de las dosis, no se necesita volver a empezar, solo llévelo al pediatra para que le apliquen la siguiente. Consulte al médico de su hijo si tiene preguntas sobre las vacunas.

NOTAS A PIE DE PÁGINA:

* Se recomiendan dos dosis con un intervalo de por lo menos cuatro semanas para los niños de 6 meses a 8 años que reciben por primera vez la vacuna contra la influenza y para otros niños en este grupo de edad.

§ Se requieren 2 dosis de la vacuna HepA para brindar una protección duradera. La primera dosis de la vacuna HepA se debe administrar durante los 12 y los 23 meses de edad. La segunda dosis se debe administrar 6 a 18 meses después. La vacuna HepA se puede administrar a todos los niños de 12 meses de edad o más para protegerlos contra la hepatitis A. Los niños y adolescentes que no recibieron la vacuna HepA y tienen un riesgo alto, deben vacunarse contra la hepatitis A.

Si su niño tiene alguna afección que lo pone en riesgo de contraer infecciones o si va a viajar al extranjero, consulte al pediatra sobre otras vacunas que pueda necesitar.



Para más información, llame a la línea de atención gratuita
1-800-CDC-INFO (1-800-232-4636)
o visite
http://www.cdc.gov/vaccines

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

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APPENDIX A. CHILDHOOD IMMUNIZATION INFORMATION FOR CONSUMERS

Enfermedades prevenibles con las vacunas y vacunas para prevenirlas

Enfermedad	Vacuna	Enfermedad transmitida por	Signos y síntomas de la enfermedad	Complicaciones de la enfermedad
Varicela	Vacuna contra la varicela.	Aire, contacto directo	Sarpullido, cansancio, dolor de cabeza, fiebre	Ampollas infectadas, trastornos hemorrágicos, encefalitis (inflamación del cerebro), neumonía (infección en los pulmones)
Difteria	La vacuna DTaP* protege contra la difteria.	Aire, contacto directo	Dolor de garganta, fiebre moderada, debilidad, inflamación de los ganglios del cuello	Inflamación del músculo cardiaco, insuficiencia cardiaca, coma, parálisis, muerte
Hib	La vacuna contra la Hib protege contra *Haemophilus influenzae* serotipo b.	Aire, contacto directo	Puede no causar síntomas a menos que la bacteria entre en la sangre	Meningitis (infección en las membranas que recubren el cerebro y la médula espinal), discapacidad intelectual, epiglotitis (infección que puede ser mortal en la que se bloquea la tráquea y origina graves problemas respiratorios) y neumonía (infección en los pulmones), muerte
Hepatitis A	La vacuna HepA protege contra la hepatitis A.	Contacto directo, comida o agua contaminada	Puede no causar síntomas, fiebre, dolor de estómago, pérdida del apetito, cansancio, vómito, ictericia (coloración amarilla de la piel y los ojos), orina oscura	Insuficiencia hepática, artralgia (dolor en las articulaciones), trastorno renal, pancreático y de la sangre
Hepatitis B	La vacuna HepB protege contra la hepatitis B.	Contacto con sangre o líquidos corporales	Puede no causar síntomas, fiebre, dolor de cabeza, debilidad, vómito, ictericia (coloración amarilla de los ojos y la piel) dolor en las articulaciones	Infección crónica del hígado, insuficiencia hepática, cáncer de hígado
Influenza (gripe)	La vacuna influenza protege contra la gripe o influenza.	Aire, contacto directo	Fiebre, dolor muscular, dolor de garganta, tos, cansancio extremo	Neumonía (infección en los pulmones)
Sarampión	La vacuna MMR** protege contra el sarampión.	Aire, contacto directo	Sarpullido, fiebre, tos, moqueo, conjuntivitis	Encefalitis (inflamación del cerebro), neumonía (infección en los pulmones), muerte
Paperas	La vacuna MMR**protege contra las paperas.	Aire, contacto directo	Inflamación de glándulas salivales (debajo de la mandíbula), fiebre, dolor de cabeza, cansancio, dolor muscular	Meningitis (infección en las membranas que recubren el cerebro y la médula espina), encefalitis (inflamación del cerebro), inflamación de los testículos o los ovarios, sordera
Tosferina	La vacuna DTaP* protege contra la tosferina (*pertussis*).	Aire, contacto directo	Tos intensa, moqueo, apnea (interrupción de la respiración en los bebés)	Neumonía (infección en los pulmones), muerte
Poliomielitis	La vacuna IPV protege contra la poliomielitis.	Aire, contacto directo, por la boca	Puede no causar síntomas, dolor de garganta, fiebre, náuseas, dolor de cabeza	Parálisis, muerte
Infección neumocócica	La vacuna PCV protege contra la infección neumocócica.	Aire, contacto directo	Puede no causar síntomas, neumonía (infección en los pulmones)	Bacteriemia (infección en la sangre), meningitis (infección en las membranas que recubren el cerebro y la médula espinal), muerte
Rotavirus	La vacuna RV protege contra el rotavirus.	Por la boca	Diarrea, fiebre, vómito	Diarrea intensa, deshidratación
Rubéola	La vacuna MMR** protege contra la rubéola.	Aire, contacto directo	Los niños infectados por rubéola a veces presentan sarpullido, fiebre y ganglios linfáticos inflamados	Muy grave en las mujeres embarazadas: puede causar aborto espontáneo, muerte fetal, parto prematuro, defectos de nacimiento
Tétano	La vacuna DTaP* protege contra el tétano.	Exposición a través de cortaduras en la piel	Rigidez del cuello y los músculos abdominales, dificultad para tragar, espasmos musculares, fiebre	Fractura de huesos, dificultad para respirar, muerte

* La vacuna DTaP combina la protección contra la difteria, el tétano y la tosferina.
** La vacuna MMR combina la protección contra el sarampión, las paperas y la rubéola.

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APPENDIX B. FOR STATE OF MARYLAND EMPLOYEES AND RETIREES

What's New for 2015 Health Care Coverage

Top 10 Highlights:

1. Effective January 1, 2015, the State of Maryland's Employee and Retiree Health and Welfare Benefits Program (the Program), will no longer offer the following:
   - Aetna POS or EPO plans
   - CareFirst POS plan (except for SLEOLA* members)
   - UnitedHealthcare POS plan
   - United Concordia DHMO plan

   *State Law Enforcement Officers Labor Alliance

2. There will no longer be a separate plan provider for mental health and substance abuse treatment. Coverage will instead be offered as a part of the medical plan.

3. A new Integrated Health Model (IHM) health benefit plan will be available through Kaiser Permanente to participants in the Baltimore-Washington, D.C. area. Kaiser Permanente has a regional network and is not available to individuals outside their service area or to those who are eligible for Medicare.

4. Delta Dental is the new carrier for the DHMO Plan, offering a national network. United Concordia will continue to be the carrier for the DPPO dental plan, with a new expanded network and a new higher annual maximum coverage benefit.

5. The Program will be introducing a New Wellness Program to help State employee and retiree participants:
   - get healthy or stay healthy
   - preserve the current level of benefits
   - promote more informed use of health care services

6. This new Wellness Program will include weight management, nutrition education and tobacco cessation programs, and will be provided at no cost for employees.

7. All lab services and x-rays will be covered at 100%, with no copay or coinsurance when an in-network provider is used.

8. Employees, retirees and covered spouses who complete the healthy activities requirements for each year will be eligible for wellness rewards.

9. New copays are in effect for acupuncture for chronic pain management and chiropractic services.

10. Subsidized medical and prescription coverage will be offered at 75% for contractual/variable hour employees who work more than 30 hours/week or 130 hours/month. Dental coverage will not be subsidized, however individuals can elect coverage assuming 100% of the cost. Accidental death and dismemberment as well as life insurance coverage options will continue to be offered at 100% of the cost to active employees.

APPENDIX B. FOR STATE OF MARYLAND EMPLOYEES AND RETIREES

WHAT'S NEW FOR 2015 HEALTH CARE COVERAGE

Wellness Program*

The Program will include a new Wellness Program for all State employees, retirees and enrolled spouses beginning January 1, 2015. The goal is to encourage and educate members to begin "moving forward to better health." The Wellness Program will require employees, retirees and enrolled spouses (not enrolled children) to complete healthy activities throughout the calendar year. If these activities are completed, enrollees will enjoy enhanced benefits such as waived copays for all Primary Care Physician (PCP) visits. For each individual (employee, retiree, and covered spouse) who does not complete all of the health activities for that year, a surcharge will be deducted from the employee's or retiree's biweekly or monthly check/pension allowance, but not before 2016.

NOTE: Wellness Program does not apply to SLEOLA members.

Year 2015: Healthy Activity Requirements	
▶ Employees, retirees and covered spouses must designate a Primary Care Physician (PCP) either on your plan's State of Maryland dedicated website or by calling your carrier. ▶ Employees, retirees and covered spouses must complete the health risk assessment which can be obtained on your plan's website or by calling your medical plan. Each employee/retiree and covered spouse must personally review their health risk assessment with their selected PCP. PCP must sign-off confirming review.	
Rewards for meeting the 2015 Healthy Activity Requirements:	PCP copayments waived for employees, retirees and covered spouses.
Penalties for not meeting the 2015 Healthy Activity Requirements:	For each individual, the employee and retiree will have a $50 surcharge which will be deducted from your bi-weekly ($2.08) or monthly ($4.16) pay starting January 1, 2016.

Year 2016: Healthy Activity Requirements	
Participants not identified for participation in the Disease Management Program	**Participants with a chronic condition identified for participation in the Disease Management Program**
▶ Employees, retirees, and covered spouses are required to complete a Nutrition Education or Weight Management program sponsored by your medical carrier.	▶ Employees, retirees and covered spouses are required to actively participate in the disease management program sponsored by your medical carrier and follow all treatment guidelines of the care manager or complete the disease management program recommended.
▶ Employees, retirees and covered spouses are required to complete the health risk assessment which can be obtained on your plan's website or by calling your medical plan. Each employee and covered spouse must personally review their health risk assessment with their selected PCP. PCP must sign-off confirming review.	▶ Employees, retirees and covered spouses are required to complete the health risk assessment which can be obtained on your plan's website or by calling your medical plan. Each employee and covered spouse must personally review their health risk assessment with their selected PCP. PCP must sign-off confirming review.
▶ Employees, retirees, and covered spouses are required to complete all recommended age/gender specific biometric screenings and discuss results with your PCP.	▶ Employees, retirees, and covered spouses are required to complete all recommended age/gender specific biometric screenings and discuss results with your PCP.
Rewards for meeting the 2016 Healthy Activity Requirements:	PCP copayments waived for employees, retirees and covered spouses.
Penalties for not meeting the 2016 Healthy Activity Requirements:	▶ For each individual, the employee and retiree will have a $50 surcharge which will be deducted from your bi-weekly ($2.08) or monthly ($4.16) pay starting January 1, 2017. ▶ If you are identified as having a chronic condition you must engage with the plan's nurse and follow the recommended treatment plan. If you do not, an additional $250 surcharge will be deducted from your bi-weekly ($10.42) or monthly ($20.84) pay starting January 1, 2017.

APPENDIX B. FOR STATE OF MARYLAND EMPLOYEES AND RETIREES

Help Resolving Issues

State of Maryland employees who have a problem with the care or service provided by a state health benefit plan must first use the plan's internal process for resolving issues. If the problem cannot be resolved through the internal appeals process, the employee can request an external review of the denial by the Maryland Insurance Administration (MIA). If an external review is requested, the MIA will review and provide a final, written determination. If the MIA decides to overturn the insurance carrier's decision, the MIA will instruct the insurance carrier to provide coverage or payment for the health care item or service. If a claim is denied because the service was not a covered service, and therefore not eligible for an independent external review, the employee may contact the Adverse Determinations Department of the Employee Benefits Division.

State of Maryland Guide to your Health Benefits, January 2015 – December 2015
http://dbm.maryland.gov/benefits/Documents/Benefits%20Guide%20CY2015.pdf

CONTACTS:

Maryland Insurance Administration
Attn: Appeals and Grievance Unit
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202
Telephone: (410) 468-2000
Toll-free: 1-800-492-6116
Facsimile: (410) 468-2270
TTY: 1-800-735-2258

Employee Benefits Division
Attn: Adverse Determinations
301 West Preston Street, Room 510
Baltimore, MD 21201
Telephone: (410) 767-4775
Toll-free: 1-800-307-8283
Facsimile: (410) 333-7104

For more information on State of Maryland employee and retiree benefits, please go to Maryland's State Employee and Retiree Health and Welfare Benefits Program website at: **www.dbm.maryland.gov/benefits**

Maryland Health Care Commission

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877-245-1762 or 410-764-3460 • TYY 800-735-2258 • FAX 410-358-1236

http://mhcc.maryland.gov